STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
El Dorado Care and Rehab	900 Country Club Lane El Dorado, KS 67042

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 0692 Level of Harm - Actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide a vegetarian diet to meet the resident's nutritional needs and failed to initiate weight loss interventions for R31, to prevent a significant weight loss of 16.30 percent (%) in 19 days. Additionally, the facility failed to provide R2 with a breakfast meal on scheduled dialysis (procedure where impurities or wastes were removed from the blood) treatment days, to meet R2's nutritional needs. Findings included:- R31's Electronic Medical Record (EMR) revealed diagnoses of diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin). R31's comprehensive Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS documented she had behaviors of rejection of evaluation for 1-3 days in the look-back period, and she required supervision or touching for eating. R31's MDS documented she did not receive a therapeutic diet, and she received parenteral or intravenous (IV) feeding (is the administration of nutrients directly into the bloodstream through a vein, completely bypassing the digestive system) while a resident. The MDS documented a proportion of total calories the resident received through parenteral, or tube feeding, was 25 percent or less, and the average fluid intake per day by IV or tube feeding was 500 milliliters (ml) or less while a resident in the past seven days. R31's Nutritional Status Care Area Assessment (CAA), dated 03/30/26, documented R31 admitted to the facility for IV antibiotic therapy due to a recent hospitalization for urinary tract infection (UTI-an infection in any part of the urinary system). R31's MDS documented she was at risk for dehydration related to recent urinary tract infection and need for IV therapy, electrolyte imbalance, worsening infection, and decline in overall condition related to recent UTI and need for IV therapy. R31's Base-Line Care Plan, dated 03/20/26, included an intervention noting R31's food preference was vegetarian. R31's Care Plan, dated 03/25/26, included an intervention for staff to monitor and record R31's meal intakes, and to provide a Registered Dietician (RD) to evaluate and make recommendations as needed. R31's Care Plan, dated 04/02/26, included an intervention for staff to provide and serve R31's diet as ordered. R31's diet was noted as a vegetarian diet, regular texture, and thin liquids. The staff were instructed to complete weekly weights four times, then monthly, or as needed. R31's Physician Orders, documented dietary supplements may be used when determined appropriate by interdisciplinary team or RD may initiate specific order for resident, dated ordered 03/20/26. R31's Physician Orders documented an order dated 03/20/26 for R31 to receive a vegetarian diet, regular texture. R31's weights in the EMR documented:03/21/25 at 01:33 AM weighed 153.4 pounds (lbs.).03/21/26 at 11:01 AM weighed 156.2 lbs. R31's Nutrition: RD admission (Initial) Assessment, dated 03/25/26, revealed the source of the nutritional information was obtained from the medical record. The option for resident or family was not checked off. Most recent weight documented on 03/21/26 at 11:01 AM weighed 156.2 lbs. The current diet was vegetarian and the average meal intake since admission was documented as poor, less than 50 percent of meals. R31 received a vegetarian diet, and her intake was 25-50 percent. R31 appeared to be tolerating her diet consistency. The assessment included R31's admitting weight was normal, and she had a Body Mass Index (BMI is a numerical value derived from an adult's weight and height, used as a screening tool to (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

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F 0692 Level of Harm - Actual harm Residents Affected - Few	estimate body fat and categorize individuals as underweight, healthy weight, overweight, or obese) of 25.4. The assessment noted the RD would monitor her weight trends and reassess as indicated. R31's Progress Note, dated 03/22/26 at 01:56 PM, documented R31 fed herself, had a poor appetite, and claimed to be a vegetarian. R31's Provider History and Physical Note, dated 03/23/26 at 07:00 AM, documented the resident was seen today for admission to the facility. R31 had poor intake since being on Mounjaro (medication diabetes to improve blood sugar control), had weight loss, and she reported she still has a poor appetite and was asking for small frequent portions. R31's Nutrition: Dietary Manager Initial Assessment, dated 03/30/26 at 05:27 PM, revealed the source of the nutritional information was obtained from the medical record, resident, and staff. R31's weight on 03/21/26 was 156.2 lbs. and her current diet order was a vegetarian diet, regular texture, and thin liquids. R31's intake was poor since admission, averaging less than 50 percent recorded. R31 was very particular about what she ate, and her husband brought food in for her often. Intake of meals the facility provided was poor. However, she ate what her husband brought to her, but amount she ate was unknown. R31's weights in the EMR documented:04/02/26 at 12:27 PM weighed 156.2 lbs.04/04/16 at 04:46 PM weighed 132.8 lbs. R31's Alert Note, on 04/04/2026 at 06:25 AM, revealed R31 refused her meal, and noted family brings in food. R31's EMR lacked a progress note on 04/04/26 after 04:46 PM regarding R31's weight loss. R31's Nursing Vital Signs Note, dated 04/06/26 at 09:00 AM, revealed the provider was in the facility and updated on R31's low blood pressure, however the note lacked evidence the staff updated the provider regarding R31's weight loss. R31's Progress Note, on 04/08/26 at 01:33 PM, documented the provider was in the facility, notified of the resident's weight loss and not eating well, and noted the provider would be reviewing. During a concurrent observation and interview on 04/06/26 at 10:02 AM, R31 sat up in her bed, in her room. R31 said when she admitted to the facility on a Friday evening a few weeks ago, the marketer of the facility told her the facility would be able to accommodate her vegetarian diet. R31 reported the staff did not know she required a vegetarian diet, and the facility was still having issues with following the vegetarian diet. R31's family member was also in R31's room and said the facility did not offer vegetarian food choices, when R31 gets a regular menu ticket. R31's family member said he had to bring food into the facility, so R31 would have something to eat. On 04/07/26 at 08:40 AM, R31 sat up in her bed with her covered breakfast tray in front of her. R31 reported she needed to have care provided to her ostomy (surgical opening from an area inside the body to the outside) bag before she ate. Certified Nurse Aide (CNA) P and CNA O assisted R31 with care and sat R31 on the side of the bed. At 09:05 AM, CNA O uncovered breakfast tray, revealing a piece of toast, a bowl of oatmeal, coffee, and milk. R31 stuck her finger into the oatmeal and mumbled the oatmeal was cold. Neither CNA O nor CNA P addressed R31's cold oatmeal concern and they exited the room. At 09:07 AM, R31's family member picked up the bowl of oatmeal and took it to the kitchen. On 04/07/26 at 09:09 AM, Dietary Staff DD exited the kitchen door and handed a bowl of oatmeal to R31's family member and reported she warmed the oatmeal up in the microwave in the kitchen. On 04/07/26 at 11:24 AM, Dietary Staff BB entered the kitchen during meal prep observation, she had R31's meal ticket for lunch and supper for 04/07/26. Each meal choice had a black line drawn diagonally across all the food choices. Dietary Staff BB reported she needed to review the meal ticket with R31 to see what she would like to eat. The meal ticket was observed to be labeled as a regular diet, regular texture. The meal ticket lacked the vegetarian diet and had chicken, cheeseburger, hot dog, and sloppy joe listed as choices. There was an everyday option of grilled cheese, peanut butter and jelly, or cold cut sandwich. Dietary Staff BB reported she did not have a meal ticket to offer for a vegetarian diet. Dietary Staff CC reported it was difficult to provide R31 her vegetarian diet when she did not have the choices she may need on her meal ticket. Dietary Staff BB reported she had to order the resident soy burgers and had not done that yet. During an observation on 04/08/26 at 01:06 PM, staff assisted R31 to the wheelchair scale, located by Licensed Nurse (LN) H. The staff zeroed the wheelchair scale out and pushed R31 onto the scale in her wheelchair. The weight on the display was 184.8 lbs. The staff assisted R31 back to her (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	room, where R31's family also wrote the weight down and asked to know what the wheelchair weighed so he could know her weight loss. During an observation on 04/08/26 at 01:26 PM, CNA T brought R31's wheelchair out of her room that had the oxygen tank, seat cushion, foot pedals and lift sling on the wheelchair, as R31 had those items on the wheelchair when she was weighed at 01:06 PM. CNA T zeroed out the wheelchair scale, pushed the wheelchair onto the scaled, and the wheelchair weight displayed on scale was 56.4 lbs. CNA T wrote the weight down and gave the results to LN H, and she reported that R31's weight was 128.4 lbs. During an interview on 04/08/26 at 10:45AM Administrative Nurse F reported R31's vegetarian diet was not considered a therapeutic diet. During an interview on 04/08/26 at 11:03 AM, Consultant Staff HH said Dietary Staff BB should have changed the program when printing out R31's menus, so she could have choices for her vegetarian diet she had ordered since admission. During an interview on 04/08/26 at 12:45 PM, LN H reported she documented R31's weight in the EMR as 132.8 lbs. on 04/04/26. LN H reported she did not complete a re-weight and said the provider should have been updated and thought the provider had ordered an appetite stimulant already. LN H reviewed R31's EMR for orders and reported there was no appetite stimulant or supplements ordered. LN H reported R31 was a vegetarian and did not like the choices at the facility. LN H reported R31's family member brought food into the facility that R31 liked, but she barely eats that. LN H reported R31 was very picky. On 04/08/26 at 01:30 PM, Dietary Staff BB reported she had not looked at R31's weight documented on 04/04/26. When she reviewed the EMR she reported she did not believe R31's admission weight at the facility was correct and had no comment to R31s weight from today of 128.4 lbs. On 04/08/26 at 01:54 PM Administrative Nurse D reported she did not know R31 had a weight loss on 04/04/26. Administrative Nurse D reported the staff had difficulty getting the resident to eat and she reported that R31's family member brings her food in, all the time. Administrative Nurse D reported she did not realize R31's meal ticket choices were for a regular diet and not a vegetarian diet. On 04/09/26 at 09:42 AM, Consultant Staff HH reported he had not been updated at this time of a weight loss for R31. Weights were reviewed with Consultant Staff HH, and he reported it was a concern and would address it with Dietary Staff BB. The facility's policy Nutrition (Impaired)/Unplanned Weight Loss - Clinical Protocol, dated 10/2025, documented monitor and document the weight and dietary intake of residents in a format which permits readily available comparisons over time. As part of a nutritional assessment the interdisciplinary team will define the resident's current nutritional status through assessments. Supplementation strategies to increase a resident's intake of nutrients and calories may include fortification of foods (for example, protein added to mashed potatoes), increasing portion. Closely monitor residents who have been identified as having impaired nutrition or risk factors for developing impaired nutrition. - Resident (R) 2's Electronic Medical Record (EMR) revealed diagnoses of end-stage renal disease (ESRD-a terminal disease of the kidneys), and moderate protein-calorie nutrition (a severe nutritional deficiency caused by inadequate intake or absorption of protein and calories energy). R2's admission Change Minimum Data Set, (MDS) dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R2's MDS revealed he required set up for eating; he had weight loss and no therapeutic diet. R2s Nutritional Status Care Area Assessment (CAA), dated 12/08/25, documented R2 consumed a regular diet. R2's Body Mass Index (BMI is a numerical value derived from an adult's weight and height, used as a screening tool to estimate body fat and categorize individuals as underweight, healthy weight, overweight, or obese) was higher than recommended for his height. R2 was not currently on a planned weight loss program and has not voiced a desire to lose weight. R2's Quarterly MDS, dated [DATE], documented a BIMS score of 15 indicating intact cognition. MDS documented R2 had no behaviors and required set-up assistance for eating. R2 had weight loss and received a therapeutic diet and required dialysis. R2's Care Plan, dated 12/16/25, revealed staff instructed to provide and serve diet as ordered. Regular diet and texture, and thin liquids. R2's Care Plan, dated 04/07/26, lacked documentation regarding dialysis treatment and current diet order of renal dialysis diet, regular texture, thin consistency. R2's (continued on next page)

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F 0692 Level of Harm - Actual harm Residents Affected - Few	Physician Orders documented renal dialysis diet, regular texture, and thin consistency date ordered 02/12/26. R2's Physician Orders documented dialysis treatment Monday, Wednesday, and Friday at Dialysis Center, his chair time was 06:20 AM. R2's Weights reviewed from 11/26/25 through 04/08/26, no concerns noted. R2's Progress Note, dated 02/12/26 at 03:46 PM, documented R2 had dialysis appointment on 02/13/26 and would be leaving at 05:20 AM. R2's Nutrition Assessment Note, dated 02/19/26 at 12:34 PM ,documented R2's current weight was 215.2 pounds on 02/13/2026. R2's current diet order was therapeutic renal diet and R2's meal intakes were good at averaging 76-100 percent. Per documentation, the resident required set-up or clean-up with eating. R2 completes dialysis three times per week. Will continue monitor weight trends; reassess as indicated. R2's current intakes are adequate to meet estimated needs. R2's Progress Note, dated 03/18/2026 at 04:35 AM, documented R2 up and ready for dialysis, transported per facility van, accompanied by facility staff. R2's Progress Note, dated 03/23/2026 at 08:23 AM, R2 moved to a different dialysis center and his chair time changed to 05:15 AM which started 3/25/26. R2's Nutrition Amount Eaten documented in tasks on EMR reviewed from 02/13/26 through 04/08/26 revealed for breakfast meal intake documented on 02/13/26, 02/16/26, 02/23/26, and 03/06/26 R2 was not available. The breakfast meal intake documented on 02/20/26, 02/25/26, 02/27/26, 03/02/26, 03/09/26, 03/10/26, 03/13/26, 03/18/26, 03/20/26, 03/23/26, 03/25/26, 03/27/26, 03/28/26, 03/29/26, 04/01/26, 04/02/26, and 04/08/26 breakfast meal was documented non applicable. On 04/06/26 at 02:45 PM, R2 was seated up in his bed completing a crossword puzzle. He reported that he just returned from dialysis. R2 reported that he leaves very early in the morning to be at the dialysis center by 05:00 AM and stated that he does not eat breakfast before he goes to dialysis, as he is not provided one and he is not provided a snack to eat at the center. On 04/07/26 at 07:56 AM, R2 was in bed looking at a book, he reported he did not think he would get up today and was waiting for his breakfast. On 04/08/26 at 05:42 AM, Certified Nurse Aide (CNA) V reported that R2 did not have breakfast this morning and reported that he would usually refuse the breakfast. CNA V reported that there was not an actual meal prepared for R2 to be offered to be refused on dialysis days though. CNA V said to ask CNA S, as she always worked on R2's hallway. On 04/08/26 at 05:44 AM, Licensed Nurse (LN) K reported that R2 started dialysis in February 2026 and cannot recall that he had been offered a breakfast meal before he left for dialysis when he worked those mornings. On 04/08/26 at 06:12 AM, CNA S reported the kitchen was closed at the time R2 woke up to go to dialysis. CNA S reported we do not have alternatives to give him for a meal. She reported that she did not offer any snacks, food, or drinks to take with him to dialysis. On 04/08/26 at 09:20 AM, Dietary Staff BB (Certified Dietary Manager) reported R2 refused to have breakfast before dialysis, and she reported that it was not documented in R2's progress notes or R2's care plan. Dietary Staff BB reported that R2 verbalized to her that was his preference. On 04/09/26 at 09:42 AM, Consultant Staff HH (Registered Dietician) reported that R2 should be offered breakfast in the morning before dialysis and reported it was expected that if R2 refused to have a breakfast meal prior to dialysis, it should be documented in the EMR. The facility's policy Dialysis, Care for a Resident, dated 03/2026, documented communication between the community, and the dialysis facility shall contain nutritional and fluid management, including resident's compliance with diet, and/or after dialysis. The facility's policy Frequency of Meals, dated 10/2025, documented that each resident would receive at least three meals daily, at regular times, comparable to normal mealtimes in the community or in accordance with the resident needs, preferences, requests, and plan of care. The facility will serve at least three meals or their equivalent daily at scheduled times. There will not be more than a fourteen (14) hour span between the evening meal and breakfast. The facility will provide alternative nourishing meals and snacks to residents who want to eat outside scheduled meal service or at non-traditional times.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. Based on record review and interview, the facility failed to submit complete and accurate staffing information through the Payroll Based Journal (PBJ) as required. This deficient practice placed the residents at risk for unidentified and ongoing inadequate nurse staffing. Findings included: - The PBJ report provided by the Centers for Medicare and Medicaid Services (CMS) for Fiscal Year (FY) 2026 Quarter 1 and FY 2025 Quarter 3 had excessively low weekend staff.On 04/08/26 at 10:44 AM, Administrative Staff A stated she was aware there was a problem and found that the previous Business Office Manager (BOM) had submitted the information incorrectly. She stated she was working with her new BOM to make sure it was being submitted correctly.The facility's Payroll Based Journal F851 policy, dated 10/25, documented that the community would submit the payroll data in a uniform format to CMS, including staffing information for community, agency, and contract staff. The direct care staff are those individuals who, through interpersonal contact with residents or resident care management, provide care and services to allow residents to attain or maintain the highest practicable physical, mental, and psychosocial well-being. Direct care staff does not include individuals whose primary duty is maintaining the physical environment of the long-term care facility. The data would be submitted electronically based upon specifications determined by CMS, and the reported information would be for direct care staff and would specify whether the individual was an employee of the facility or is engaged by the facility under contract or through an agency.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. Based on interviews, observation, and record review, the facility failed to utilize Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) when providing wound care to a Resident (R) 2 with a Foley catheter (tube inserted into the bladder to drain urine into a collection bag), colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body), and a hemodialysis port (a subcutaneous vascular access device placed under the skin to provide long-term access for hemodialysis {procedure where impurities or wastes were removed from the blood}). The facility further failed to ensure adequate hand hygiene during care for R43, R31 and R8. Findings included: - During an observation on 04/07/26 at 08:16 AM, Certified Nurse Aide (CNA) O and CNA P provided peri-care care to R43. CNA O opened R43's drawer and removed a tube of barrier cream, with the same gloved hand she used to provide R43's peri-care, then began to apply barrier cream to R43's buttocks. CNA O then removed her gloves and did not perform hand hygiene before she applied a new pair of gloves. CNA P did not change her gloves after assisting R43 with pericare, in which R43 had a small, soft bowel movement, and continued to assist R43 with clothing. CNA P then removed her gloves and walked over to the glove box, but it was empty. CNA P did not perform hand hygiene after removing her soiled gloves, grabbed the doorknob and exited the room. CNA P returned to R43's room and applied new gloves. An interview on 04/07/26 at 03:17 PM revealed CNA O and CNA P both said they did not realize they had to wash their hands when they removed soiled gloves during care. CNA O reported she did not realize she had used her soiled gloved hand to open the drawer and apply the barrier cream to the resident. CNA P reported she did not think to change her gloves after she cleansed the bowel movement from R43 and before she assisted R43 to dress. During an observation on 04/07/26 at 08:40 AM, CNA P provided ostomy care to R31. CNA P removed R31's ileostomy (surgical formation of an opening through which fecal matter empties) bag and wafer, cleansed around the stoma, used the same soiled gloves to open the box of ostomy supplies, removed a new bag/wafer from the box, and applied the device to R31's abdomen. CNA O then opened a drawer with gloved hands and removed wipes and barrier cream. CNA P applied new gloves, then opened the bathroom door and the closet door and removed a brief. CNA P cleansed R31's buttocks and applied the barrier cream to her buttocks. CNA P removed her gloves and, without performing hand hygiene, assisted R31 with her brief. CNA O removed her gloves without performing hand hygiene, applied new gloves, opened the closet door, and removed R31's clothes. An interview on 04/07/26 at 03:30 PM revealed CNA O and CNA P both said they did not realize they had to wash their hands when they removed gloves during care. CNA P reported she was able to complete ostomy care, and she said she should have washed her hands before removing a new ostomy bag from the supply box. CNA P and CNA O stated they did not realize they used their soiled gloved hands to open drawers and closets, to gather supplies. During an observation on 04/07/26 at 09:30 AM, Consultant Staff JJ provided wound care to R8. Consultant Staff JJ removed the soiled dressings from the outer right side of R8's foot and distal end of right great toe. Consultant Staff JJ removed her gloves and asked Consultant Staff KK for a measuring stick and wound wash. Consultant Staff JJ applied new gloves without performing hand hygiene. Consultant Staff KK wiped the top of the bottle of wound wash with a sanitation wipe. Consultant Staff KK then sprayed a 4x4 gauze dressing with wound wash and cleansed the open wound on R8's outer right foot. Consultant Staff KK cleansed the open wound with a 4x4 gauze a few times without flipping the gauze. Consultant Staff KK then kept her gloves on after washing the wound and gave a wet 4x4 gauze to Consultant Staff JJ. Consultant Staff KK then opened a new dressing and handed the dressing to Consultant Staff JJ, with the same gloved hands she used to clean the open wound on R8. Consultant Staff JJ placed the dressing on the barrier, then she took her phone out of her back pocket and tried to type on her phone the wound measurements. Consultant Staff JJ removed the glove off of her right hand and typed the (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	measurements into her phone. Consultant Staff JJ applied a new glove onto her right hand but did not perform hand hygiene. Consultant Staff KK handed Consultant Staff JJ another dressing. Consultant Staff KK then opened a 2x2 dressing and handed the dressing to Consultant Staff JJ. Consultant Staff KK continued to wear the gloves she wore to clean the wound on R8, and opened and closed drawers on the treatment cart in R8's room. After she applied a dressing to the area on the distal end of R8's right great toe, Consultant Staff JJ removed her gloves, took her phone out of her pocket, and took a picture of R8's outer right foot. Consultant Staff KK then went into R8's closet with the same soiled gloves and removed a packet of 2x2 dressings. Consultant Staff JJ typed measurements into her phone and put the phone back in her pocket, without performing hand hygiene prior to applying clean gloves and then applied the dressing to R8's right outer foot. Consultant Staff KK washed off the treatment cart with a sanitation wipe, wearing the same soiled gloves she wore since she washed R8's right outer foot open wound. Consultant Staff KK and Consultant Staff JJ removed their PPE and then performed hand hygiene. During an interview on 04/07/26 at 10:14 AM, Consultant Staff KK and Consultant Staff JJ reported they should have performed hand hygiene after removing their gloves, and Consultant Staff JJ said she generally would remove both of her gloves. Consultant Staff KK stated she thought she used a different 4x4 when she cleansed the wound and confirmed she left her gloves on the entire time, touching dressing supplies, the cart, and door handles. Consultant Staff KK reported she should have removed her gloves after she cleaned the wound and performed hand hygiene. During an observation on 04/07/26 at 10:10 AM, Consultant Staff II, Consultant Staff JJ, Consultant Staff KK, and another unknown wound care team member were in R2's room (a resident on EBP). R2 was positioned on his right side facing the window as two of the Consultant Staff members assisted him. Consultant Staff II reported they were almost finished with his wound care. Observation revealed none of the Consultant Staff in R2's room performing wound care wore a gown as required; they all wore gloves only for the wound care. During an interview on 04/07/26 at 10:13 AM, Certified Medication Aide (CMA) R reported R2 was on EBP as R2 had a colostomy, urinary catheter, and a dialysis port in his left chest. CMA R reported staff were required to wear a gown and gloves when direct care was provided. During an interview on 04/07/26 at 10:14 AM, Consultant Staff II reported they should wear the required personal protective equipment (PPE- gowns, face shields and/or eyeglasses/goggles, and gloves) if a resident was on EBP and confirmed none of the consultant staff had worn a gown when they provided wound care for R2 that morning. During an interview on 04/07/26 at 10:19 AM, Administrative Nurse E (Infectious Preventionist) stated she expected the wound care staff to use the PPE gowns and gloves for residents that have EBP. She said she expected the wound care staff and the facility staff to perform hand hygiene when gloves were removed. Administrative Nurse E reported she expected all wounds to be cleansed by standards of care. She also expected the staff and wound care staff not to wear soiled gloves to touch clean items or residents. The facility's policy Enhanced Barrier Precautions, dated 04/2025, documented expand the use of PPE and refer to the use of gown and gloves during high-contact resident care activities that provide opportunities for transfer of multiple drug-resistant organism (MDRO-common bacteria that have developed resistance to multiple types of antibiotics) to staff hands and clothing. MDROs may be indirectly transferred from resident-to-resident during these high-contact care activities. Residents with wounds and indwelling medical devices are at especially high risk of both acquisition of and colonization with MDROs. The use of gown and gloves for high-contact resident care activities are indicated. The facility's policy Handwashing/Hand Hygiene, dated 10/2025, documented the facility considers hand hygiene the primary means to prevent the spread of infections. Employees must wash their hands for at least twenty (20) seconds using antimicrobial or non-antimicrobial soap and water under the following conditions:Before and after direct resident contact (for which hand hygiene is indicated by acceptable professional practice), after removing gloves, and before handling clean or soiled dressings, and gauze pads.

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NAME OF PROVIDER OR SUPPLIER El Dorado Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Country Club Lane El Dorado, KS 67042	

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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** Based on observation, interview and record review the facility failed to store and label biologicals adequately when staff failed to date an insulin (medications used to treat high blood glucose levels) pen when opened and failed to remove or dispose of four expired bottles of stock medications. This deficient practice placed the residents at risk to receive expired, ineffective insulin and other residents at risk to receive expired ineffective stock medications. Findings included:.- On [DATE] at 08:05 AM, observation of the 100-200 hall medication cart revealed the following:R41's Novolog (long-acting insulin) pen without an open date or the discard date.On [DATE] at 08:15 AM, observation of the treatment cart revealed four expired stock medication bottles which included:ASA (pain and anti-inflammatory medication) 325 milligrams (mg), expired 01/26.Vitamin D (vitamin supplement) 100 tablets, expired 03/26.Calcium (bone building supplement) 600 mg and Vitamin D 5 micrograms (mcg), expired 07/25.Zinc (mineral supplement) 50 mg. 100 tablets, expired 01/26. On [DATE] at 8:10 AM, Certified Medication Aide M verified the stock medication had expired. On [DATE] at 08:20 AM, Licensed Nurse (LN) G verified the undated insulin pen and stated staff were to date the insulin pens when they are opened. The facility's Medication Storage policy, dated 03/2026, stated the facility would store all drugs and biologicals in a safe, secure, and orderly manner. The facility staff shall not use discontinued, outdated, or deteriorated drugs or biologicals and shall be returned to the dispensing pharmacy or destroyed per state regulations.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, record review, and interview the facility failed to prepare and serve food under sanitary conditions to prevent the potential for food borne bacteria and illness. Findings included:- Observation of the kitchen and food storage areas on 04/06/26 at 07:59 AM revealed the following areas of concern: The kitchen prep counter had staff's personal items laid on the counter, including a purse and a tumbler with a straw. The personal items laid next to several bags of undated hamburger and hot dog rolls. Two of the bags of rolls were not sealed. One bag of the hot dog rolls had three rolls that had fuzzy green colored areas on the rolls.Two bags of unsealed and undated potato chips laid on the same counter. At 08:01 AM, temperature logs hung on the front of the refrigerator door in the kitchen, which lacked recorded temperatures on 03/03/26, 03/04/26, and 03/05/26. Dietary Staff FF looked at the temperature logs and stated staff were to record the temperatures at least daily, and said there were a lot of new staff. At 08:05 AM continued initial tour of the kitchen revealed the following areas of concern: In the Kitchen refrigerator:Wilted lettuce dated 04/04/26, in an unsealed bag.One container of beef base, which lacked an opened date.A container of mustard and relish, not dated when opened.Two packages of unsealed, undated deli meats.Two containers of opened, honey thickened liquid, one dated 02/09/26 and the other 02/10/26. The directions noted the items were to be disposed of seven days after opening.One cup of covered cottage cheese, undated.Several small single serve containers of salsa, undated. In the dry storage:One dented can of Cheese Sauce in the front rotation of big, canned items, dated 03/20/26.One box of gravy mixes and two large cans of apple pie filling, stored directly on the floor.One bag of unsealed rice cereal on the shelf.One large bag of unsealed spaghetti.One large box of lasagna noodles, unsealed, due to the lid on the box was partially open. In the walk-in cooler:No dates documented on the temperature log sheet for the walk-in cooler and walk in freezer for 03/03/26, 03/04/26, and 03/05/26.One unsealed bag of celery, and lettuce that was unsealed and wilted.One big bowl of batter covered with tin foil dated 04/04/26, not labeled.One bag of unsealed sausage patties.A large container of egg salad dated 03/28/26.A yellow pastry/cake covered loosely with a piece of tin foil, dated 03/30/26.A container of undated and unlabeled meat in brown fluid. Walk-in freezer:One box of pork laid directly on the freezer floor.One bag of chicken laid directly on the freezer floor.The internal thermometer in the walk-in freezer was found on the floor. The floor of the walk-in cooler and freezer had a lot of debris, which appeared to be old food crumbs. On 04/07/26 at 11:09 AM, the walk-in freezer internal thermometer read zero degrees Fahrenheit. Observation revealed all the temperature log sheets for the walk-in cooler, walk-in freezer, kitchen refrigerator and freezer now had documented temperatures for the dates which were not filled in on 04/06/26 initial tour. On 04/07/26 at 11:15 AM, Dietary Staff CC reported he just placed all the cooked chicken, beans, and marinara sauce on the steam table. On 04/07/26 at 11:21 AM, Dietary Staff CC started prep for the pureed diet, as he waited for the food processor container to wash in dishwasher in-between pureeing foods, Dietary Staff CC was drinking coffee from a large disposable cup and placed that cup on the kitchen counter next to an uncovered cake, cut up and ready for service. On 04/07/26 at 11:32 AM, Dietary Staff CC placed the pureed food he prepared in the fridge, covered with foil. During an observation on 04/07/26 at 11:33 AM, Dietary Staff EE walked in the back door of kitchen with a basket of clean kitchen linens and did not wear a hairnet. At 11:35 AM Dietary Staff EE entered the kitchen without a hair net and placed a bag in the trash can by the food prep area. Dietary Staff BB told Dietary Staff EE to put on a hairnet on. On 04/07/26 at 11:51 AM, Dietary Staff CC checked the temperature of the food on the steam table, and used one paper towel to wipe off the thermometer in between checking the food temperatures. On 04/07/26 at 11:54 AM, Dietary Staff BB placed sanitizing thermometer wipe packets on the counter. On 04/07/26 at 11:56 AM, Dietary Staff CC removed the prepared pureed food from the refrigerator, removed the foil, and poured the pureed noodles onto the plate. He placed the uncovered food into the (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	microwave for one minute, then took the plate out and checked the temperature of the chicken, beans, and noodles in-between temperature checks and used the sanitation wipe to wipe off the food. He placed the plate back into the microwave uncovered for one minute, checked the temperatures of the chicken, beans, and noodles in-between temperature checks and used the sanitation wipe to wipe off the food. On 04/07/26 at 11:37 AM, Dietary Staff EE reported she should have applied her hairnet before she entered the kitchen. On 04/07/26 at 12:50 PM, Dietary Staff CC reported he generally used a paper towel to clean the thermometer in-between checking the food temperatures. Dietary Staff CC reported he has always drunk coffee in the kitchen when he works. He reported that he should have covered the plate of food before he placed it in the microwave. On 04/06/26 at 08:30 AM, Dietary Staff BB reported she expected the staff to check the temperatures of the refrigerator, freezer, walk-in cooler, and walk-in freezer and document them on the form three times a day. Dietary Staff BB expected staff to label, date, and seal all dry, cold, or frozen food and dispose of food when it was outdated, wilted, or moldy. Dietary Staff BB reported the egg salad should have been disposed by day seven on 04/04/26. Dietary Staff BB expected staff not to store any food items on the floor and to keep the kitchen areas clean. On 04/07/26 at 01:00 PM, Dietary Staff BB reported she expected the staff to apply a hairnet before they entered the kitchen, then reported she observed Dietary Staff CC use the same paper towel to wipe off the thermometer in-between food temperature checks, and said that was why she laid the wipes on the counter. She expected the staff to use one wipe after each time the thermometer was used. Dietary Staff BB reported she expected the staff to never eat or drink in the kitchen and had not seen the staff do that, she expected the staff not to have any personal food, drink or items in the kitchen. Dietary Staff BB reported she expected the staff to cover the food in the microwave. On 04/08/26 at 11:03 AM, Consultant Staff HH reported completed a monthly kitchen inspection and reported nothing was perfect. Consultant Staff HH reported he expected the staff to wear a hairnet in the kitchen. Consultant Staff HH expected the staff to never drink, eat, or have personal items in the kitchen. He expected the staff to check the temperatures of the refrigerator, freezer, walk-in cooler, and walk-in freezer and document them on the form three times a day and expected staff to label, date, store and seal all dry, cold or frozen food and dispose of food when it is outdated, wilted or moldy. Consultant Staff HH expected the staff to keep the kitchen areas clean and sanitize the thermometer the proper way. The facility's policy Preventing Foodborne Illness - Employee Hygiene and Sanitary Practices, dated 10/2025, documented food Services employees shall follow appropriate hygiene and sanitary procedures to prevent the spread of foodborne illness. Hair nets must be worn when cooking, preparing, or assembling food to keep hair from contacting exposed food, clean equipment, utensils and linens. Personnel may not eat or drink in the food preparation area. The facility's policy Sanitation, dated 10/2025, documented all kitchen areas and dining areas shall be kept clean, and free from litter and rubbish. The facility's policy Food Safety Requirements, dated 10/2025, documented foods shall be received and stored in a manner that complies with safe food handling practices. Food Services, or other designated staff, will always maintain clean food storage areas. Food in designated dry storage areas shall be kept off the floor (at least 6 inches) and clear of sprinkler heads, sewage/waste disposal pipes and vents (at least 18 inches). Dry foods that are stored in bins will be removed from original packaging, labeled, and dated. All foods stored in the refrigerator or freezer will be covered, labeled, and dated. Functioning of the refrigeration and food temperatures will be monitored at designated intervals throughout the day by the Food Service Manager or designee and documented according to state-specific requirements.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. Based on observation and interview, the facility failed to promote dignity for one resident, Resident (R) 36, whose were exposed to other residents when his pants started to fall. Findings included:- On 0/06/26 at 11:55 AM, observation revealed during meal service, R36 stood up from the dining table. When he started to walk, his pants fell below his abdomen, and the top of his buttocks were exposed. Further observation revealed R36 grabbed onto the waistband of his pants to hold them up. An elderly female resident, R34, stated, I just saw that man's butt.On 06/07/26 at 12:10 PM, R36 was at the nurse's station on the phone. While he was standing there, the plaid pajama pants had slipped below his abdomen, and approximately a quarter of his buttocks were exposed. As R36 walked to the dining room, he kept pulling up his pants to keep them up.On 06/08/26 at 11:00 AM, Licensed Nurse (LN) I stated R36 did not have a weight loss, so she did not know why his clothes were not fitting correctly, and that she would investigate the situation.On 06/08/26 at 12:50 PM, Administrative Nurse E stated that R36 had money he needed to spend down and had already planned to buy him some new clothes with it and agreed it was a dignity issue and felt bad the other residents were in the dining room to see it.The facility's Respect and Dignity, Right to Personal Property, Including Searches and Illegal Substances policy, dated 06/25, documented residents have the right to be treated with respect and dignity, unless to do so would infringe upon the rights and safety of other residents. Staff shall provide person-centered care that emphasizes the residents' comfort, independence, and personal needs and preferences. Staff shall accommodate to the fullest extent possible the use of personal possessions, including furnishings and clothing, unless to do so would infringe upon the rights or health and safety of other residents.

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 residents; 14 residents were sampled for advanced directives (a written document, which indicates the medical decisions for health care professionals when the person could not make their own decisions). Based on interview and record review, the facility failed to ensure one resident's advanced directives were honored. Resident (R) 8's completed do not resuscitate (DNR- or no code, a legal document or order that means the person does not desire resuscitative measures) order was discontinued on [DATE]. Findings included:R8's Electronic Medical Record (EMR) revealed diagnoses of tracheostomy status (opening through the neck into the trachea through which an indwelling tube may be inserted), chronic respiratory failure (CRF - a long-term, ongoing condition where the respiratory system fails to properly exchange oxygen and carbon dioxide, resulting in persistently low oxygen), and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R8's Annual Minimum Data Set (MDS), dated [DATE], documented a brief interview for mental status (BIMS) could not be completed as resident was rarely/never understood. Staff assessment completed and documented R8 had severely impaired cognition. R8's MDS documented that he required total assistance for all activities of daily living. R8's Cognitive Loss/Dementia Care Area Assessment (CAA), dated [DATE], documented R8 was a long-term resident at the facility with a primary diagnosis of chronic respiratory failure. R8 required a tracheostomy. R8 was nonverbal and rarely communicated and was dependent on all cares. R8's Order Approving Written Certification of Treating Physician and Concurrence, dated [DATE], documented the matter that comes before the court upon guardian's (a person or entity legally entrusted with the care, protection, and management of another person typically an incapacitated adult) presentation of a physician's certificate in accordance with Kansas Statutes Annotated 59-3507 (e)(7)(C). Upon review of presented certification, the Court finds the physician's certificate and concurring certification of the second physician are in proper form and approved. The Guardian and Conservator shall have the authority to consent on behalf of the ward to the withholding of life-saving medical care, treatment, services or procedures. R8's EMR had an uploaded DNR dated [DATE] that was signed by one physician, the guardian, and two witnesses. R8's Physician Orders, documented a DNR date ordered [DATE] when he admitted to the facility, that was discontinued on [DATE]. R8's Physician Orders, documented full code, all measures date ordered [DATE]. R8's Care Plan, dated [DATE], instructed staff to initiate cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) when appropriate and continue until Paramedics arrive to take over, and review quarterly and as needed. R8's Provider Note, dated [DATE], documented code status DNR. R8's Provider Note, dated [DATE] at 11:00 PM, documented the Director of Nursing notified the provider that R8 required a DNR form in his chart. R8 was ordered a full code until two physicians can sign the form stating R8 was a DNR candidate and the durable power of attorney (DPOA- a legal document that names a person to make healthcare decisions when the resident is no longer able to) would work court side to get that finalized. R8's Progress Note, dated [DATE] 01:09 PM, revealed R8's code status updated to full code pending guardians completing court process for DNR. Provider notified of need for DNR letters for guardians. Message left for guardians. R8's Care Conference Note, dated [DATE], documented discussed care options with guardian and he would like to transition R8 from a full code to a DNR. Guardian reported that R8 had originally had a DNR and the state made them change him to a full code. Guardian was okay to start the process of transitioning R8 to a DNR and continue to follow up with guardian per request. On [DATE] at 09:15 AM, R8 lay in his bed with head of bed elevated, observed a red abrasion, approximate size 0.5 centimeter (cm) x 2 cm, surrounded by slight redness in color of the right forehead. R8 had a lot of facial hair, and he shook his head side to side in a no motion when he (continued on next page)

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F 0578 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	was asked if he wanted a shave. He shook his head side to side in a no motion when asked him if he had a fall. [DATE] at 11:22 AM, R8's Guardian reported that R8 used to be a DNR and reported the state did an audit last year and he had to be full code. Guardian reported he could not understand why and has asked the facility for assistance. On [DATE] at 02:45 PM, Licensed Nurse (LN) J reported she could not recall why R8's DNR was discontinued in [DATE]. On [DATE] at 02:50 PM, Social Service Designee (SSD) X revealed that a mock survey by regional staff had been completed in [DATE]. SSD X reported she was told R8's DNR was not good as it was signed after the guardianship paperwork was in effect. SSD X reported that the Director of Nursing at the time had R8's provider discontinue the DNR and reported she was a bit confused when that occurred. SSD X reported she had not spoken to R8's guardian about a request to have assistance to have a DNR completed. On [DATE] at 03:02 PM, Administrative Staff A, Administrative Nurse D, and Administrative Nurse E reviewed R8's EMR of the DNR, progress notes, orders, and guardian ship paperwork, and they all reported that they had no knowledge of the concern that the guardian had about the DNR. Administrative Nurse D reported that R8's Guardian wanted R8 to be a full code when she had spoken to guardian about hospice. Administrative Staff A reported that R8's paperwork for the DNR was accurate and directed Administrative Nurse E to contact the Guardian to see what they wanted to do with R8's code status. The facility's policy Advance Directives, dated 05/2025, documented advance directives would be respected in accordance with state and federal law and facility policy. Prior to or upon admission of a resident, the Social Services Director or designee would inquire about the resident, and/or his/her family members, about the existence of any written advance directives. Information about whether the resident has executed an advance directive shall be displayed prominently in the medical record.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review the facility failed to identify, monitor, and respond to an injury of unknown origin/skin condition identified as and abrasion and redness on Resident (R) 8's forehead. Findings included:- R8's Electronic Medical Record (EMR) revealed diagnoses of chronic respiratory failure (CRF is a long-term, ongoing condition where the respiratory system fails to properly exchange oxygen and carbon dioxide, resulting in persistently low oxygen), and schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). R8's Annual Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed as the resident was rarely/never understood. Staff assessment revealed R8 had severely impaired cognition. R8 had no behaviors and required total assistance for all activities of daily living. R8's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 04/28/25 documented R8 was nonverbal, rarely communicated, and was dependent on all cares. R8's Quarterly MDS dated [DATE] documented the resident had no change in mental status, behaviors, or assistance required with activities of daily living R8's Care Plan, dated 04/26/23, revealed staff were instructed to inspect the resident's skin weekly and as needed. Staff would observe R8 for redness, open areas, scratches, cuts, bruises, and report any changes to the nurse. R8's Weekly Skin Note, reviewed from 03/28/26 and 04/02/26, revealed no documentation for an abrasion or bruise to R8's forehead. During an initial observation (on the first day of the facility's annual resurvey) on 04/06/26 at 09:15 AM, R8 laid in his bed with the head of his bed elevated. The resident had a red abrasion, which measured approximately 0.5 cm by 2 centimeters (cm) present on the right side of his forehead. R8 shook his head side to side in a motion indicating no, when asked if he had a fall. R8's progress notes lacked evidence that staff identified the abrasion to R8's forehead and/or investigated the origin of the injury until the next day on 04/07/26. R8's Progress Note, dated 04/07/26, at 05:10 PM documented R8 had a purple abrasion to the right side of his forehead. The area was closed and measured 0.3 cm by 2.5 cm by 0 cm. R8 was unable to describe how the injury occurred. Staff were questioned about the origin of the resident's injury, and no event was noted to occur. The note indicated R8's head may have hit the wall during cares. R8 recently had a room change, and his bed was placed against the wall. A fall mat was placed to the left side of the resident's bed to prevent him from grazing his head on the wall. During an interview on 04/07/26 at 09:54 AM Certified Nurse Aide (CNA) O reported she had not noticed the abrasion/redness on R8's forehead. During an interview on 04/07/26 at 02:29 PM, Licensed Nurse (LN) J reported that she was told by the night nurse on 04/06/26 that R8 had an abrasion on his forehead and she was not sure how it happened. LN J reported that she did not document the area on R8's forehead as she thought the night nurse did. During an interview on 04/07/26 at 03:33 PM, CNA O reported that any new skin issue identified on a resident would be reported to the nurse. The staff were required to write a statement for an injury such as a bruise, or skin tear. During an interview on 04/07/26 at 05:01 PM, Administrative Nurse E stated she was not aware that R8 had an abrasion on his forehead and reported that the nurse should have reported, assessed, and completed a risk management for the abrasion. Administrative Nurse E further stated a root cause analysis should have been completed to assess how R8 would have received an abrasion.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review and interviews, the facility failed to provide written notification of a bed hold for a facility-initiated transfer for Resident (R) 5 when they were transferred to the hospital and failed to notify the State Long Term Care Ombudsman (LTCO) of facility-initiated transfers/discharges for R5. Findings included: - R5's Electronic Medical Record (EMR) recorded diagnoses of anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), chronic kidney disease Stage 3 (moderate to severe loss of kidney function), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R5's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R5 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS recorded R5 required staff assistance with most activities of daily living (ADLs). The MDS recorded R5 received dialysis (a procedure where impurities or wastes are removed from the blood), and oxygen therapy. The Activities of Daily Living (ADLs) Care Area Assessment (CAA), dated 07/01/25, recorded R5 required substantial assistance with ADLs requiring the lower body, he is unable to ambulate and had poor balance. R5 would operate his wheelchair with set-up assistance and was a fall risk. The ADL Care Plan, dated 12/16/25, recorded staff would assist R5 with ADLs and ambulation as needed. The care plan documented that staff would monitor and report changes in mental status, lethargy, tiredness, fatigue, tremors, seizures and breathing difficulties. The care plan documented R5 had renal insufficiency due to chronic kidney disease and staff would monitor lab results, electrolytes, and report to the physician results. The Nurse's Note, dated 12/09/25 at 01:13 PM, documented the lab called the facility and stated the resident had a critical lab hemoglobin (Hgb-measure of blood that carried oxygen to the cells from the lungs and carbon dioxide away from the cells to the lungs) of 6.1 (normal 13.5 to 17.5 grams per deciliter (g/dl) for men). The Nurse's Note, dated 12/09/25 02:15 PM, documented the facility received a call from the provider to send R5 to the emergency room due to the critical lab values. The 12/09/25 at 02:40 PM, Nurse's Note documented R5 left the facility via stretcher per ambulance. The 12/16/25 at 06:06 PM, documented R5 returned to the facility from the hospital for end stage renal disease and anemia. R5 had a dialysis port on the left upper chest. R5's clinical lacked evidence of the bed hold policy and the facility was unable to provide evidence upon request. The facility was unable to provide evidence that the facility notified the LTCO of the resident's transfer/discharge from the facility. On 04/08/26 at 09:30 AM, Social Service X verified the facility lacked a bed hold notice when R5 was discharged to the hospital and verified the Ombudsman was not notified of the resident's discharge to the hospital. The facility's Bed Hold policy, dated May 2026, documented the facility staff shall inform residents upon admission and prior to a transfer for hospitalization (unless for an emergency) or therapeutic leave of the bed-hold policy. The policy documented upon admission and when a resident is transferred for a non-emergency hospitalization or for therapeutic leave, a representative of the business office would provide information concerning the bed hold. When emergency transfers are necessary, the facility would provide the resident and the resident representative with information concerning the bed-hold policy per state law as applicable. A copy of the resident's bed hold policy would be filed in the resident's medical record. Upon request the facility failed to provide an Ombudsman Notification policy

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide consistent bathing for two residents, Resident (R) 22 and R37. The facility failed to provide grooming for R43, who had facial hair and dirty fingernails.Findings included:- R22s Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and atrial fibrillation (rapid, irregular heartbeat). The Quarterly Minimum Data Set (MDS), dated 01/ 06/26, documented a Brief Interview for Mental Status (BIMS) of 8, indicating moderately impaired cognition. R22 required substantial staff assistance with lower body dressing and showers, and partial staff assistance with personal hygiene. R22's Care Plan, dated 01/29/26, directed one staff member to assist with bathing and use a shower chair, initiated on 10/07/22. The April 2026 Shower Sheets documented R22 had not received a bath or shower during the following days: 04/01/26-04/07/26 (7 days) The April 2026 Shower Sheets documented R22 refused her shower on 04/01/26. The March 2026 Shower Sheets documented R22 had not received a bath or shower during the following days: 03/01/26-03/30/26 (30 days) The March 2026 Shower Sheet documented R22 refused her shower on 03/20/26 and 03/25/26. On 04/06/26 at 09:46 AM, R22 had stains on her pants and had multiple chin hairs. On 04/08/26 at 08:00 AM, Certified Nurse Aide (CNA) N stated there are bath sheets that are used with the skin assessment and if the resident refused. CNA N further stated that she would reapproach the resident if they refused bathing and notified the nurse. On 04/08/26 at 11:00 AM, Licensed Nurse (LN) I stated R22 refused bathing but was sure she had been provided with showers since February, but staff could not force her to take one. LN I further stated, if a resident refused, they would reapproach. Staff document on a shower sheet, given to the nurse, and placed in a basket on the desk. LN, I stated, she was unsure what happened to them after that. On 04/08/26 at 12:50 PM, Administrative Nurse D stated R22 refused her baths and that they had a lot of agency staff in and she had to hunt them down to do shower sheets so some of the showers were probably not documented. The facility's Quality of Life-Activities of Daily Living policy, dated 03/26, documented the facility assisted the residents in maintaining and/or achieving independent functioning, dignity, and (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	well-being. Residents who are unable to carry out activities of daily living received the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. Residents are provided with services including hygiene, mobility, elimination, dining, and communication. - R37's Electronic Medical Record (EMR) documented diagnoses of benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and polyneuropathy (a chronic disorder resulting from damage to multiple peripheral nerves simultaneously). The Annual Minimum Data Set (MDS), dated [DATE], documented intact cognition. R37 required supervision with showers, lower body dressing, toileting hygiene, and transfers. The 03/25/26 Care Plan included the following interventions for R37: 10/18/22- I prefer to have staff shave him with razors. 11/04/22- I require one staff participation with personal hygiene and oral care. 11/04/22- I require one staff participation with bathing. I like to shower two times a week on Monday and Thursday mornings. 03/27/24- I can get my own clothes ready for the day and able to pick my own clothes. The March 2026 Shower Sheets and Bathing Record documented R37 requested showers on Monday and Thursday dayshift and lacked documentation R37 received the requested two showers. The March 2026 Shower Sheet lacked documentation R37 refused his showers. The February 2026 Shower Sheets and Bathing Record documented R37 requested showers on Monday and Thursday dayshift and lacked documentation R37 received the requested two showers. The February 2026 Shower Sheets and Bathing Record lacked documentation R37 refused his showers. On 04/06/27 at 10:16 AM, R37 was unshaven, and he stated that he had not received his showers as requested. R37 stated he had spoken to staff and was told that he refused his showers. R37 requested to see the shower sheets that he would have signed if he had refused his showers. but staff were unable to find those shower sheets. On 04/08/26 at 9:15 AM, Certified Nurse Aide (CNA) N stated R37 did not typically refuse his showers. If a resident refused, she would reapproach and tell the nurse. On 04/08/26 at 11:15 AM, Licensed Nurse (LN) I stated a resident can have as many baths as possible per week as they wanted. LN I further stated there had been times in the past the bath aide was pulled to the floor to work as the CAN, and stated that may be why he had not received his showers twice a week. On 04/08/26 at 12:50 PM, Administrative Nurse D stated she expected R37 to receive his showers (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	twice a week as preferred. The facility's Quality of Life-Activities of Daily Living policy, dated 03/26, documented the facility assisted the residents in maintaining and/or achieving independent functioning, dignity, and well-being. Residents who are unable to carry out activities of daily living received the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene. Residents are provided with services including hygiene, mobility, elimination, dining, and communication. - R43's Electronic Medical Record (EMR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and 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). R43's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) could not be completed as the resident was rarely/never understood. Staff assessment revealed R31 had severely impaired cognition. R4 required total assistance for personal hygiene. R43's Communication Care Area Assessment (CAA), dated 10/17/25, documented R43 relied on staff to have her needs met, daily. R43's Care Plan, dated 02/03/23, revealed R43 required one staff assistance with personal hygiene. R43's Care Plan, dated 05/08/25, revealed staff were instructed to assist the resident with grooming and hygiene to the extent needed. On 04/06/26 at 10:20 AM, R43 sat in her wheelchair, in the dining room, and had several facial hairs on her chin that measured approximately 0.25 inches long. Her fingernails had a brown substance underneath them and were jagged. On 04/07/26 at 08:16 AM, Certified Nurse Aide (CNA) O and CNA P provided morning cares to R43 who laid on her bed. R43 continued to have several facial hairs on her chin, her fingernails had a brown substance underneath them, and they were jagged. On 04/07/26 at 12:45 PM R43 continued to have facial hair on her chin, fingernails had a brown substance underneath them, and they were jagged. During an interview on 04/07/26 at 03:17 PM, CNA O reported the facility had a bath aide that was scheduled on first and second shift, Monday through Friday. CNA O stated she was taught not to shave residents and reported the nurse would shave the residents. CNA O further reported the nurse would cut all the residents' nails but noted the bath aide cleaned the residents' nails. During an interview on 04/07/26 at 03:48 PM, CNA Q reported she was the bath aide for second shift and would complete the scheduled showers. CNA Q reported she shaved residents if they requested it. She reported she would provide nail care but would not cut diabetic nails. CNA Q reported she would clean residents' nails on shower days, and if any additional nail concerns were identified the residents' nails would be cleaned then. CNA Q reported it was hard to shave R43 as she moved her head, which made it hard to shave her. CNA Q reported she could not always understand R43. (continued on next page)

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	During an interview on 04/07/26 at 03:53 PM, Licensed Nurse (LN) J reported the staff were expected to offer and complete facial hair removal/shaving, and nails were to be cleaned on shower days and if needed or requested. LN J reported the nurse was required to cut fingernails for all the residents and noted the CNAs did not cut any resident fingernails. During an interview on 04/07/26 at 04:10 PM, Administrative Nurse E stated she expected the CNAs to file, clean, and trim fingernails for the residents on their bath day and as needed. The nurse would cut the resident's fingernails that were diabetic. Administrative Nurse F expected the CNAs to remove facial hair on shower days and as needed. She also reported that facial hair should be removed when requested and per the resident's preferences, which would be documented on the resident's care plan. The facility policy Quality of Life-Activities of Daily Living, dated 03/26, documented the facility assisted the residents in maintaining and/or achieving independent functioning, dignity, and well-being. Residents who are unable to carry out activities of daily living received the necessary care and services to maintain good nutrition, grooming, and personal and oral hygiene.

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F 0685 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assist a resident in gaining access to vision and hearing services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on interview and record review, the facility failed to ensure dependent Resident (R) 43 received staff assistance in placing his hearing aids, which placed the resident at risk for social isolation, mental decline, and loss of independence. Findings included:- R43's Electronic Medical Record (EMR) revealed diagnoses of dementia (progressive mental disorder characterized by failing memory, confusion) and 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), and malformation of ear causing hearing impairment. R43's Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) that could not be completed as the resident was rarely/never understood. Staff assessment revealed R31 had severely impaired cognition. R43's MDS revealed she wore a hearing aide. R43's Communication Care Area Assessment (CAA), dated 10/17/25, documented R43 relied on staff to have her needs met. R43's Quarterly MDS, dated [DATE], documented no change in the resident's BIMS or hearing aid use. R43's Care Plan, dated 01/03/23, revealed staff would ensure availability and functioning of adaptive communication equipment, which included a message board and a hearing aid to the right ear. R43's Care Plan, with a revised date of 01/29/25, instructed staff to provide her hearing aid for the right ear, which was to be worn during the day and taken off at night. The case was to be left at the nurses' station and charged overnight. R43's Physician Orders documented the resident could be seen by specialists as needed including audiologist of choice and they were to provide care as needed, dated 01/30/23. R43's Activities Note, dated 08/29/25 at 11:40 AM, documented R8 was hearing impaired and wore a hearing aid in the right ear, when available. R43's Activities Note, dated 09/30/25 at 10:23 AM, documented R8 had limited communication and was hearing impaired. On 04/06/26 at 10:20 AM, R43 sat in her wheelchair with no hearing aid noted. On 04/07/26 at 12:45 PM, R43 sat in the dining room with no hearing aid observed in her right ear. On 04/06/26 at 10:20 AM, Activity Director Z reported that R43 did not have a hearing aid. The staff had to speak loudly in her right ear so she could hear. Activity Director Z reported that R43 did not speak often. On 04/07/26 at 09:47 AM, Certified Nurse Aide (CNA) N and Certified Medication Aide (CMA) R reported that R43 did not have a hearing aid, and they had never seen one. On 04/07/26 at 03:17 PM, CNA P and CNA O reported that R43 did not have a hearing aid, and they did not know if she was care planned for the use of a hearing aid. On 04/07/26 at 04:30 PM, Administrative Nurse F reported that R43 required a hearing aid and was care planned for the use of a hearing aid to the right ear. Administrative Nurse F reported she was not sure if R43 had a hearing aid. On 04/07/26 at 04:36 PM, Activity Director Z reported that R43 had not used a hearing aid since they quit working some time last year. She reported the resident's hearing aid would not hold a charge. Activity Director Z stated she had informed a nurse about the residents' hearing aid. On 04/07/26 at 04:50 PM, Social Service Designee (SSD) X reported R43's hearing aid broke four or five months ago. SSD X tried to contact R43's durable power of attorney and was unable to get ahold of him about the hearing aid. She was not sure if the hearing aid would be covered or if R43 had personal funds to cover the hearing aid repair and reported that this was documented in R43s EMR. SSD X reported she did not think that R43 ever had an appointment with an audiologist. On 04/08/26 at 11:00 AM, Activity Director Z reported R43 had a hearing aid that charged at that nurse's desk. Activity Director Z then applied the hearing aid into R43's right ear and R43 smiled. On 04/08/26 at 01:54 PM, Administrative Nurse D stated that she expected staff to make sure resident hearing aids were offered and placed on the residents as ordered. Administrative Nurse D reported that an unnamed facility nurse purchased R43 a hearing aid and she was not sure when it arrived but noted that it had been at the nurse's desk charging. The facility did not provide a policy for hearing aids.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide adequate supervision to ensure a safe environment for one resident, Resident (R) 22, who had multiple falls in the facility dining room, and failed to follow her plan of care. Findings included:- R22's Electronic Medical Record (EMR) documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), atrial fibrillation (rapid heartbeat), and muscle weakness. The Quarterly 5-Day Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) of eight, indicating moderately impaired cognition. R22 required partial staff assistance for eating, mobility, transfers, and did not ambulate. R22 had no functional impairment and had no falls since the prior assessment. The Quarterly MDS, dated 01/06/26, documented a BIMS of 8, indicating moderately impaired cognition. R22 was dependent upon staff for transfers, toileting hygiene, and had partial staff assistance for mobility. R22 had no functional impairment, no falls since prior assessment, and did not ambulate. The Fall Assessments, dated 10/08/25, 01/08/26, 01/25/26, and 03/16/26, documented R22 a high risk for falls. The 01/29/25 Care Plan included the following interventions for R22:11/12/24- Ensure she is wearing non-slip footwear. If the gripper socks are too worn, remove them from her inventory and contact the family.3/24/24- Floor mat on the exit side of the bed to decrease the risk of injury when R22 gets out of bed.12/06/25- Staff are not to leave residents in the dining room after meals unattended.12/21/25- Do not transfer to the dining room chair for meals; leave her in her wheelchair to prevent falls.02/24/26- Antithrust cushion placed with Dycem (non-slip mat used for stabilization and gripping to prevent falls) to wheelchair.03/11/26- Remove Hoyer (full mechanical lift) sling from the wheelchair after transferring R22.03/16/26- PT to evaluate and treat for walk to dine to prevent falls.03/28/26- Staff educated on the interventions put into place on 12/21/25, not to leave her unattended in the dining room. The intervention would be added to an assigned task for each shift. Offer toileting and to lay her down after meals. Adjust her bed routine to fit the resident's preference to go to bed earlier, offering her to go to bed when she starts showing signs of fatigue. The Fall Investigation, dated 12/21/25 at 05:25 PM, documented staff found R22 on the floor in the dining room by a Certified Nurse Aide (CNA). The investigation documented R22 had been one-on-one all afternoon due to wanting to stand up and walk. R22 told staff she wanted to go home. R22 was assessed for injuries, and the family was notified. R21 was oriented to person, had gait imbalance, impaired memory, and was impulsive. The Fall Investigation, dated 03/11/26 at 05:00 PM, documented that another resident was heard calling for help in the dining room to inform staff that R22 had slipped out of her chair onto the dining room floor. Staff found her seated on her buttocks in front of her wheelchair with her back up against her wheelchair. The two residents at R22's table stated she had just slipped and did not hit her head. The investigation further documented R22 was oriented to person, had impaired decision-making skills, had decreased strength, and had decreased safety awareness. The root cause analysis for the fall was that the sling from the lift should be removed after the resident was transferred. The Fall Investigation, dated 03/28/26 at 11:38 PM, documented R22 was lying on the floor face down with the wheelchair at her feet. She was assessed and assisted into her wheelchair by two staff members. R22 needed to go to the bathroom after a meal and was not offered. R22 had impaired decision-making, oriented to person, impulse, and needed to go to the bathroom. On 04/06/26 at 3:27 PM, R22 was in her wheelchair, pushed by staff to the dining room with the sling still under her in the wheelchair. On 04/07/26 at 08:00 AM, CNA T placed the sling lift under R2 and attached the sling to the Hoyer lift. CNA N used the controller to lift the resident and set her into her wheelchair. After removing the sling from the lift, CNA N pushed the sling partially under R22 so it would not drag on the ground. CNA N took the sling that was behind R22 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and took the black loops on the sling and wound them onto the wheelchair handles. CNA N stated R22 had a lot of falls and that she had a fall mat beside the bed, and they made observations of her several times a day. CNA N further stated that she was able to have access to the plan of care from the computer to see all her fall interventions. On 04/08/26 at 11:00 AM, Licensed Nurse (LN) I stated R22 had falls in the dining room and that they tried to keep an eye on her because she is impulsive and often resists care. On 04/08/26 at 12:50 PM, Administrative Nurse F stated that R22 should not have been left alone in the dining room, as she is impulsive and falls. Staff should follow the care plan, and she had inadvertently put on the care plan to remove the sling, as it should not have been a fall intervention, as R22 had Dycem in her wheelchair. The facility's Assessing Falls and Their Causes Guidelines policy, dated 10/25, documented staff reviewed the residents' plan of care to assess for any special needs of the resident, the resident's current medications, and conditions. After the fall, an incident report was completed by the nursing supervisor on duty at the time of the fall, and the Director of Nursing Services would be notified no later than 24 hours after the fall occurred. The staff will evaluate the chain of events or circumstances of the fall and will determine the cause. Appropriate interventions would be taken to prevent further falls.

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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 0790 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide routine and 24-hour emergency dental care for each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review and interview, the facility failed to facilitate the necessary dental care services for Resident (R)1. Findings included: - R1's Electronic Medical Record (EMR) recorded diagnoses of gastroesophageal reflux (GERD-backflow of stomach contents to the esophagus), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and protein calorie malnutrition (a severe form of undernutrition caused by inadequate intake of protein, calories, and essential nutrients, or by high metabolic demand). R1's admission Minimum Data Set (MDS), dated [DATE], recorded R1 had a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The assessment revealed R1 was independent with oral hygiene and personal care. The assessment revealed that R1 did not have any natural teeth or tooth fragments, no inflamed or bleeding gums, and no broken or loosely fitting full or partial dentures. R1's Dental Care Area Assessment (CAA), dated 03/06/26, recorded R1 had tooth pain on her right side and started an antibiotic for a dental abscess. R1's Nursing admission Evaluation, dated 02/06/26, recorded the resident did not have her own teeth and did not have any broken or loose fitting full or partial dentures. The evaluation recorded the resident had recent weight loss. The assessment lacked any additional dental documentation. R1's Care Plan, dated 02/07/26, lacked any reference to R1's broken, decayed teeth, or the dental services to be provided. The 02/16/26 at 04:01 PM, Nurses' Notes documented R1 reported she had a tooth abscess on her tooth on the right side and reported her mouth was sore and had been hurting. The 02/16/26 at 05:22 PM, Nurses' Notes documented the nurse practitioner ordered Clindamycin (antibiotic) 300 milligrams(mg), four times a day for seven days. The 02/21/26 at 10:48 AM, Nurses Notes documented R1 continued with the antibiotics for the tooth abscess and reported decreased pain. The 02/22/26 at 12:34 AM, Nurses Notes documented the resident continued to receive Clindamycin for the abscessed teeth and denies any adverse effects at this time. On 04/06/26 at 01:30 PM, observation of R1's sitting in the side of the bed with her room tray in front of her and eating a salad. Observation revealed R1 mouth she had missing teeth, except one that was decayed and split in pieces and one that had broken off at the lower jaw. On 04/08/26 at 01:30 PM, Administrative Nuse E verified she had not visualized R1's mouth or teeth until today and verified R1 was edentulous except for the two broken teeth, and verified the resident was not currently on the facility dental services provided by an outside source. Administrative Nurse E verified R1 had not had any dental care or services since admission to the facility, and they would investigate having her see a dentist for continued dental care. The facility's Routine Dental Care policy, dated November 2025, documented that each resident would receive routine dental care. The policy documented nursing care staff would conduct ongoing health assessments to assure that each resident receives adequate oral hygiene, The attending physician would be notified of a residents' need for dental treatment and order dental consultation as appropriate The facility's routine dental care includes, but is not limited to and initial evaluation of each residents dental needs, consultation with the resident, staff, and the dental consultant, daily dental and oral hygiene plan of care, and preventative care and treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175324	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/09/2026
NAME OF PROVIDER OR SUPPLIER El Dorado Care and Rehab		STREET ADDRESS, CITY, STATE, ZIP CODE 900 Country Club Lane El Dorado, KS 67042	

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 0806 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives and the facility provides food that accommodates resident allergies, intolerances, and preferences, as well as appealing options. The facility had a census of 43 residents. The sample included 14 residents. Based on observation, record review, and interview, the facility failed to meet the nutritional needs of residents in accordance with established national guidelines, placing the residents at risk for unmet nutritional needs. Findings included:- On 04/06/26 at 09:00AM, observation revealed R48 sat in a wheelchair in her room with the bedside table in front of her awaiting her breakfast tray. Continued observation revealed at 09:30 AM a nurse aide came into R48's room and R48 inquired when her breakfast would be delivered. The nurse aide stated the kitchen had not delivered the food cart to the hall and when they did, she would deliver R48's room tray. On 04/06/26 at 10:00 AM, observation revealed R48 sat in a wheelchair in her room with her bedside table in front of her awaiting breakfast to be delivered to her room On 04/06/26 at 10:05 AM, Administrative Nurse D and Administrative Nurse E were summonsed to R48's room and the surveyor inquired when R48 would and should receive her breakfast and they stated they would check into it and verified the resident should have had her breakfast before 10:00 AM. On 04/06/26 at 10:10 AM R48 received her room tray that consisted of cream of wheat and one piece of toast. R48 stated they did not provide sugar, butter or jelly when they delivered her meal. R48 states she had asked for eggs and orange juice and the staff stated they were out of those items, and this is what they had available. On 04/06/26 at 10:15 AM, Administrative Nurse E verified the kitchen did not print a breakfast ticket for the residents and that is why she did not receive her meal. On 04/08/26 at 11:10 AM, Dietary Staff BB verified R48 had not received her breakfast meal tray because the meal ticket did not print, and staff did not know she had not received her meal and verified the supper meal on 04/05/26 her meal ticket had not printed and that is why she did not receive that supper meal until late. Dietary Staff BB verified they have corrected the issue, and they will have three check offs to be sure every resident receives their meals and they are served timely. The facility's Food Preparation and Service policy, dated 10/2025, documented residents are to be provided with food that is palatable, attractive and at a safe and appetizing temperature. The policy documented that the food service employees should prepare and serve food in a manner that complies with safe food handling practices.