STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175357	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wellington Health and Rehab	1600 W 8th Street Wellington, KS 67152

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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 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 resident. The sample included 12 residents with three residents sampled for accidents. Based on observation, interview, and record review, the facility failed to complete a thorough root cause analysis to identify causative factors and/or failed to implement the care planned interventions to prevent further falls for Resident(R) 38 and R28. This deficient practice placed the residents at risk for further falls and associated injuries. Findings included- R38's Electronic Health Record (EHR) documented diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion), a history of falling, and muscle weakness. R38’s 03/25/25 Annual Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R38 required supervision with most activities of daily living (ADLs), except set up for wheelchair mobility, bed mobility, and upper dressing. The MDS documented R38 had one fall with minor injury. R38’s 04/13/25 Falls Care Area Assessment (CAA) documented staff attempt to minimize serious injury with frequent toilet cueing, placing the call light in reach, and utilizing non-skid footwear. The CAA noted a padded beanie head protector would be applied upon arousal; staff would ambulate the resident, otherwise the resident would use a wheelchair for mobility. R38’s 06/25/25 “Quarterly MDS” documented a BIMS of six. ADLs remained the same as the Annual MDS. The MDS documented R38 had one non-injury fall. R38’s “Care Plan” dated 08/01/25, directed staff to provide a bed and chair alarm; check and change every two hours while the resident was in bed for the next 10 days. Staff were instructed to provide supervision assistance with ADLs while R38 was awake. R38’s “Fall Risk Evaluation” dated 03/16/25, 06/16/25, and 6/18/25 documented R38 was a low risk for falls. R38’s “Fall Risk Evaluation” dated 07/23/25, 08/01/25, and 08/22/25 documented R38 was a high risk for falls. R38’s “Progress Note” dated 8/1/25 at 09:35 PM, documented the resident self-propelled out of his room, dove out of his wheelchair when he struck the door jam. Staff placed R38 on fall precautions, and a bed and chair alarm were placed as interventions. During an observation on 08/24/25 at 02:54 PM, R38 was in bed. There was no bed alarm observed on his bed. A personal alarm was noted on the wheelchair. During an interview on 08/25/25 at 10:37 AM, Certified Nurse Aide (CNA) M reported that the alarm that is on his wheelchair should be moved to the bed when staff assist R38 to bed. CNA M reported that R38 required the alarm on his wheelchair and bed. During an interview on 08/26/25 at 10:05 AM, Licensed Nurse (LN) H stated she expected staff to have all fall interventions per the resident's care plan. During an interview on 08/26/25 at 10:30 AM, Administrative Nurse D reported she expected staff to follow the care plan and to always have the fall interventions in place. The facility policy titled Fall and Fall Risk, Managing F689” dated 06/2025, documented if position alarms were utilized as an intervention, the staff would monitor their placement per an established schedule. (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 - Minimal harm or potential for actual harm Residents Affected - Few	- R28's Physician Orders” dated 08/20/25, documented diagnoses of neuromuscular dysfunction of the bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system,) hypertension (high blood pressure), type 2 diabetes (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty, and irrational fear), psychosis (any major mental disorder characterized by a gross impairment in reality perception)disturbances, mood and behavior disturbances), chronic kidney disease, abnormal posture, and repeated falls. R28's 03/02/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS noted R28 had no functional impairment in range of motion (ROM) of his upper or lower extremities. He required supervision or touching and/or partial moderate assistance from staff for completion of activities of daily living (ADLs). The resident used a walker as a mobility device, and staff provided partial moderate assistance for dressing. He had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid) and was always continent of bowel without constipation. The resident fell two to six months prior to admission. No documentation of falls after admission. R28 received occupational therapy (OT) on one day of the look-back period for 40 minutes and physical therapy (PT) one day of the look-back period for 45 minutes. R28's Quarterly MDS dated [DATE] documented changes from the above MDS, which included a BIMS score of 11, indicating moderate cognitive impairment. R28 received as-needed (PRN) pain medication. He reported occasional pain frequency and rated pain as rarely or did not interfere with sleep or ADLs. The “Falls Care Area Assessment” (CAA), dated 03/03/25, was triggered for falls related to him falling before admission to the facility. He had periods of confusion/tremors. R28's Care Plan dated 03/05/25 identified the resident as at high risk for falls related to a history of falls prior to admission. The plan directed staff to position, empty, and monitor his indwelling urinary catheter; administer his medications as ordered, and monitor for side effects and effectiveness. The plan directed staff to ensure R28 wears appropriate footwear, such as non-skid socks or shoes, when ambulating or mobilizing in a wheelchair, and keep the environment and floors free from spills and/or clutter. Staff were to provide adequate glare-free lighting, a reachable call light, the bed in low position at night, handrails on the walls, and personal items within reach. Additional fall interventions initiated after falls to prevent further falls included assisting R28 to the toilet after breakfast, initiated 03/17/25. The plan directed staff to reinforce to the resident to call for assistance, directed the use of a leg bag during the day, initiated on 07/05/25. R28's “Progress Notes documented a note on 07/04/25 at 06:37 PM, which noted R28 notified the nurse that he went to the bathroom and was trying to button up his pants, lost his balance, and fell. He got himself up and ambulated to his bed. The new intervention was to provide staff training regarding infection control related to the use of a leg bag during the day. Additionally, staff were to remind the resident to call for assistance for toileting. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R28's “Progress Notes documented a note on 07/19/25 at 04:10 PM, noted that R28's roommate reported that his roommate (R28) was on the floor. The nurse entered R28’s room and noted him lying with his mid-upper back and head resting on his recliner, facing the door. He reported his right elbow and cheek hurt a little. He stated he was at the sink refilling his water glass when he got the shakes, and then just went down. Upon assessment, R28 had a slight redness noted on his right cheek. Two staff members assisted the resident to a standing position, then to his bed. He was shaky and not confident in his movement, but with encouragement and redirection, staff were able to get him stabilized and situated on the side of the bed. The staff explained to R28 that he needed to call for assistance when getting up to ambulate for the rest of the day, as he had complained of the shakes. The resident voiced his understanding. His call light was within reach on the side of his bed. Therapy services for continued evaluation and guidance with ADLs. R28's Electronic Health record (EHR) lacked evidence that a new intervention was implemented to prevent further falls. On 07/19/2025 at 10:18 PM, R28's EHR recorded an “Alert Charting for Fall follow-up” note that documented R28 stated he got tangled up in his catheter tubing. The investigation lacked consideration of the resident’s report of causative/contributing factors as part of the root cause analysis and lacked an associated intervention to prevent further falls. R28's “Progress Notes documented a note on 08/05/25 at 04:30 AM, which noted R28 sat on the floor near the restroom with his walker. The call light was attached to the pillow, and his bed was in the lowest position. R28 reported he was on his way to the restroom to have a bowel movement and lost his balance. Staff assisted the resident to the toilet and then to bed. Interventions directed staff to continue to remind resident to use the call light for assistance and therapy to continue to provide oversight, evaluation, and guidance. R28's EHR lacked evidence that a new intervention was implemented to prevent further falls. The Progress Notes documented a note on 08/21/25 at 04:15 PM that noted R28 attempted to transfer to the bathroom to have a bowel movement. He experienced tremors and lost his balance. The investigation lacked a root cause analysis and lacked a new appropriate intervention to prevent further falls. On 08/24/25 at 11:41 AM, R28 lay on his side on his bed with his legs over the side of the bed. He wore tennis shoes. Additionally, the resident’s catheter urine collection bag and tubing were positioned on the walker in the dignity bag. The resident reported he placed the collection bag in the dignity bag and then carried it when he went to the bathroom to have a bowel movement. On 08/25/25 at 11:48 AM, R28 lay in bed with a pillow roll behind his back. The catheter collection bag was positioned in a dignity bag with the tubing and bag hanging on his wheelchair beside the bed. On 08/25/25 at 11:54 AM, CNA M, entered R28’s room and asked him if she could help him with anything. R28 said no. CNA M asked if R28 wanted to go to the dining room for lunch, and he said yes. She asked if he wanted to go to the bathroom, but he said no. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 08/24/2025 at 11:41 AM, R28 stated he was supposed to turn on his call light when needing to go to the bathroom, but when he needs to go, he forgets to use his call light. He stated he had fallen going into the bathroom to have a bowel movement. He said he did not have to go to the bathroom for his bladder because the bag collected his urine. He said he did have trouble moving the bag and tubing, and he got tangled up sometimes. He said the bag is heavy when it is full. On 08/25/25 at 07:17 PM, R28’s representative said R28 had dementia, and his difficulty retaining instructions and limited safety awareness with toileting were concerning. She confirmed the facility was aware of the concerns related to the resident’s multiple falls. She stated R28 was supposed to have a catheter leg collection bag on during the day because he maneuvers his own catheter bag and tubing, and he gets tangled in it. On 08/25/25 at 11:54 AM, CNA M stated R28 was able to transfer himself with staff assistance when he gets shaky. She reported R28 knew when he needed to have a bowel movement and would turn on his call light for staff to walk with him to the bathroom. CNA M stated the resident was at risk for falls when he gets shaky, but he was good about letting the staff know when he needed to walk, and the staff assisted him to prevent him from falling. On 08/26/25 at 12:36 PM, Administrative Nurse E confirmed R28 was supposed to have a leg bag for urine collection for his catheter because the resident had fallen related to getting tangled in the catheter tubing and collection bag when transferring himself and toileting. She confirmed the care plan conference dated 08/21/25 included the discussion of the resident’s fall and review of the existing interventions. Administrative Nurse E said the use of a leg bag as a fall intervention was discussed and added to the Treatment Administration Record (TAR) on 08/22/25 to ensure staff would check for the leg bag placement. On review of the resident’s TAR, she confirmed the staff had signed the leg bag as used from 08/22/25 to current date, but said the leg bag had not been used because the resident refused, though it was not documented. Additionally, she verified the resident’s fall on 08/21/25 lacked a thorough investigation, with an intervention initiated to prevent further falls. On 08/26/25 at 12:56 PM, Administrative Nurse F confirmed on 08/21/25, staff identified concerns related to the resident’s multiple falls, and interventions were discussed during a care plan conference. She confirmed R28 had a diagnosis of dementia and often forgot to use his call light when going to the bathroom. Administrative Nurse F verified R28's Care Plan included to use a leg bag for the collection of urine from the catheter to prevent the resident from getting tangled in the straight drain urine collection bag and tubing when toileting himself. On 08/26/25 at 01:10 PM, Administrative Nurse F verified the staff had signed R28's TAR to indicate the resident had the leg bag in place, and he did not have a leg bag in place. She reported the direct care staff confirmed the leg bag had not been used as an intervention to prevent falls since 07/09/25. The facility policy titled Fall and Fall Risk, Managing F689” dated 06/2025, documentation included, “ . based on previous evaluations and current data, the staff will identify interventions related to the resident's specific risks and causes to try and prevent the resident from falling and to try to minimize complications from falling.”

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate pain management for a resident who requires such services. (continued on next page)

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F 0697 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 resident. The sample included 12 residents with two residents sampled for pain management. Based on observation, interview, and record review, the facility failed to monitor, treat and provide interventions including medication and non-pharmacological measures to manage Resident (R) 28's pain in accordance with his goals and preferences. This deficient practice placed the resident at risk for unmanaged pain, a decline in function and impaired quality of life. Findings included- R28's Physician Orders dated 08/20/25, documented diagnoses of neuromuscular dysfunction of the bladder (dysfunction of the urinary bladder caused by a lesion of the nervous system,) hypertension (high blood pressure), type 2 diabetes (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), anxiety disorder (mental or emotional disorder characterized by apprehension, uncertainty, and irrational fear), psychosis (any major mental disorder characterized by a gross impairment in reality perception)disturbances, mood and behavior disturbances), chronic kidney disease, abnormal posture, and repeated falls.R28's 03/02/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 10, indicating moderate cognitive impairment. The MDS noted R28 had no functional impairment in the range of motion (ROM) of his upper or lower extremities. He required supervision or touching and/or partial moderate assistance from staff for completion of activities of daily living (ADLs). The MDS noted R28 did not receive scheduled or as needed (PRN) medications for pain or non-medication interventions for pain. R28 received high-risk medications, which included opioids, during the look-back period. R28's Quarterly MDS dated [DATE] documented changes from the above MDS, which included a BIMS score of 11, indicating moderate cognitive impairment. R28 received PRN pain medication. He reported occasional pain that rarely interfered with sleep or his ADL. He continued to receive opioid medication during the look-back period.The Cognitive Loss/Dementia and Care Area Assessment, (CAA), dated 03/03/25, documented R28 had a BIMS score of 10 and required reminders and cues 10; He had periods of confusion. The Pain CAA did not trigger.R28's Care Plan dated 03/05/25 noted the resident had impaired cognitive function/ and directed staff to monitor, document, and report to the provider any changes in cognitive function, specifically changes in: decision-making ability, memory, recall and general awareness, difficulty expressing self, difficulty understanding others, level of consciousness, and mental status. The plan directed staff to give medications as ordered. The care plan did not address the resident's pain or list non-pharmacological interventions to address pain.The Physician Order Sheet (POS) dated 08/20/25, included the following orders: Oxycodone (opioid pain medication) 5 milligrams (mg), give half a tablet by mouth every six hours as needed for moderate to severe pain ordered 02/27/25.Acetaminophen 325 mg, two tablets by mouth every four hours for pain PRN, do not exceed 3 grams per day.R28's Medication Administration Record (MAR) dated 06/01/25 through 08/25/25, revealed R28's oxycodone was not administered.R28's MAR dated 06/01/25 through 08/25/25 documented the acetaminophen 325mg, two tablets, was given as follows:06/24/25 at 11:50 AM for pain rated a 7 out of 10 (0-10 scale where zero equals no pain and 10 equals the worst pain imaginable).06/30/25 at 08:32 AM, for pain rated 5.07/16/25 at 12:08 PM, for pain rated 5.08/05/25 at 11:00 AM, for pain rated 7.08/05/25 at 05:45 PM, for pain rated 8.08/06/25 at 012:48 PM, for pain rated 6.08/09/25 at 06:34 PM, for pain rated 6.08/10/25 at 00:17 AM, for pain rated 6. All the above pain medications were described as being effective.Review of R28's Mar or Treatment Administration Record (TAR) from 08/11/25 through 08/25/25 lacked indication the staff monitored, offered, or provided pain relief measures.On 08/25/25 at 11:48 AM, R28 laid in bed with a pillow roll behind his back. He reported he had pain in his back and beneath his right upper arm, but said he had not reported his pain to the staff. He turned his call light on. On 08/25/25 at 11:54 AM, Certified Nurse Aide (CNA) M entered R28's room and asked the resident if she could help him with anything. R28 said no. R28 did not report the presence of pain he had described six minutes earlier.On 08/25/25 at 11:59 AM, CNA M confirmed R28 did not report pain and said the resident did not recall why he had turned his call light on. CNA M reported the resident often complained of back pain, and the pillow that was behind his back was put there by the staff because it seemed to help. CNA M stated that when a resident reported pain, the staff would try to make the resident comfortable and notify the nurse, who should assess the resident. She confirmed R28 had dementia and sometimes forgot what he turned his light on for, but he would turn on his call light to let the staff know if he needed something. CNA M stated she would notify the nurse he reported pain. On 08/25/25 at 07:17 PM

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 43 residents. Based on observation, interview, and record review, the facility failed to post Nurse Staffing information for Registered Nurses, Licensed Practical Nurses, Certified Nurse Aides, the resident census, and the total number of actual hours worked by each category, daily as required. Findings included: - Review of Daily Staff Posting Sheets, dated 07/01/24 through 12/31/24, and 08/15/25 through 08/25/25, revealed the facility lacked adjustment to the Daily Staff Posting Sheets, for actual staff hours worked versus scheduled hours worked by the direct care staff.On 08/26/25 at 10:36 AM, Administrative Staff B reported her responsibilities included to make sure all the lunches were removed for any hourly employee on a monthly basis and the nursing hours were accurately submitted to the corporate office. She verified she did not report or address the redesignation or call-in coverage otherwise.On 08/26/25 at 03:38 PM, Administrative Staff A confirmed the Daily Staff Posting Sheets, noted above, lacked documentation to reflect the adjustments for call-ins, meal breaks, and change in coverage. Additionally, he reported he was not aware that the Daily Staff Posting Sheets, should be adjusted to reflect changes in the scheduled direct care staff. The facility policy, Nursing Services F725, F726, dated 08/2025, documentation included the community provides adequate staffing with 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 well-being of each resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 43 residents, and one main kitchen. 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. This placed the residents at risk for food borne illnesses. Findings included:- Observation of the kitchen and food storage areas on 08/24/25 at 09:40 AM revealed the following areas of concern:Walk-In Cooler:A white Styrofoam cooler on the top shelf, with no date and no label, contained several rolled-up items in foil. Dietary Staff CC opened one of the foil packets and reported it was hot dogs from a facility picnic the previous Thursday.Free-standing freezer:One bag of cooked bacon with no date or label.One brown bag in a zip lock bag with no date or label.One bag of sealed French fries with no date.One bag of hash browns unsealed.One bag of ready-to-bake chocolate chip cookies with no date or label.During an interview on 08/24/25 at 10:10 AM, Dietary Staff CC reported that all food items required an open date and were required to be sealed properly.During an interview on 08/25/2025 at 11:20 AM, Certified Dietary Manager BB stated she expected staff to label, date, and seal all food properly.During an interview on 08/25/25 at 01:00 PM, Administrative Staff A stated he expected all food items to be stored, sealed, labeled, and dated properly.The facility's policy Food Safety Requirements, dated 10/2024, documented food shall be received and stored in a manner that complies with safe food handling practices. All food stored in the freezer or refrigerator will be covered, labeled, and dated.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 43 resident; there were 12 residents in the sample. Based on observation, interview and record review the facility failed to maintain an infection program related to. Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resident organisms which employ targeted gown and glove use during high contact care) when providing dressing changes on a abdominal peritoneal dialysis (a home-based treatment for kidney failure that uses the patient's own abdominal lining as a filter to remove waste and excess fluid from the blood) catheter for Resident (R) 2. This placed the resident at risk for infection. Findings included:- R2's Physician Orders in the Electronic Medical Record (EMR) dated 08/19/25 revealed the following diagnoses: chronic kidney disease stage five (a condition where the kidneys gradually lose their ability to filter waste products from the blood) and type two diabetes (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R2's Annual Minimum Data Set (MDS) dated [DATE] revealed a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. R2 required supervision or touch assistance with activities of daily living (ADLs) and received peritoneal dialysis. R2's Quarterly MDS dated [DATE] documented no changes from the 12/01/24 MDS. R2's Care Plan dated 02/25/25 documented R2 has a dialysis catheter placement on 01/30/25. The plan directed staff to use Enhanced Barrier Precautions, and gowns and gloves should be worn during the following high-contact resident care activities: dressing, bathing or showering, transferring, providing hygiene, changing briefs or toileting, and wound care. On 08/25/25 at 08:15 AM, R2 was in the dining room for breakfast. R2 had a knee brace on the right knee. On 08/25/25 at 10:20 AM, R2 was in activities with the other residents playing a game. On 08/25/25 at 02:20 PM, Licensed Nurse (LN) G prepared the equipment to change R2's dressing over her peritoneal site on the lower left side of the resident's abdomen. LN G wore gloves during the procedure but did not wear a gown during the dressing change. On 08/25/25 at 03:37 PM, LN G stated she should have had a gown on before cleaning R1's catheter site. On 08/25/25 at 04:05 PM, Administrative Nurse D stated she expected staff to wear both gown and gloves for residents with EBP. The facility's policy Multidrug-Resistant Organism (MDRO) and Enhanced Barrier Precautions refers to an infection control intervention designed to reduce transmission of multidrug-resistant organisms that employs targeted gown and glove use during high-contact resident activities.