

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175397	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/23/2026
NAME OF PROVIDER OR SUPPLIER Rossville Healthcare and Rehabilitation Center		STREET ADDRESS, CITY, STATE, ZIP CODE 600 E. Perry St Rossville, KS 66533	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)		
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on record review, interview, and observation, the facility failed to maintain infection control designed to provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections for Residents (R)1, R2, R3, R4, and R5. Findings included: - 1. R1's Electronic Medical Record (EMR) documented R1 had diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle wasting, cognitive impairment, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness) pneumonia (an infection in the lungs), respiratory failure (when the lungs cannot send enough oxygen to the blood) with hypercapnia (a condition that occurs when there is too much carbon dioxide in the blood) and hypoxia (inadequate supply of oxygen), and traumatic brain injury (TBI-an injury to the brain caused by external forces). The Annual Minimum Data Set (MDS), dated 07/10/2026, documented R1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R1 had difficulty communicating some words or finishing thoughts and missed some part or intent of a message but could understand most of a conversation. The MDS documented R1 had impairment of both sides of his upper and lower extremities. The MDS documented R1 was dependent on staff for all activities of daily living (ADLs). The MDS documented R1 received oxygen therapy and required a non-invasive mechanical ventilator (CPAP- a ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/10/2026, documented R1 had diagnoses of TBI, communication deficit, and cognitive impairment. The CAA documented R1 had poor short-term memory and poor decision-making skills. The CAA documented activities were provided to keep R1 engaged. The Functional Abilities CAA, dated 07/10/2026, documented R1 was dependent on staff for all care, had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), and a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). R1 had difficulty swallowing and had a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) for nutrition. R1's Care Plan, initiated on 04/30/2017, documented R1 was on supplemental oxygen. The care plan directed staff to change R1's oxygen tubing and rinse the oxygen concentrator filter weekly. The care plan lacked any direction regarding keeping oxygen tubing off the floor (09/28/2023). The care plan documented R1 was dependent on staff for completion of all ADLs (12/27/2023). The care plan directed staff R1 enjoyed watching television, going outside when the weather was nice, watching various types of movies, listening to music, and reading about guitars. The Health Status Note, dated 07/16/2026, documented a chest X-ray had been performed on R1, and the results were bilateral poorly defined infiltrates (pneumonia), and an antibiotic, Levaquin 500 milligrams, was ordered daily via g-tube. The Infection Note, dated (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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	07/16/2023, documented an infection control assessment had been completed because R1 had a lower respiratory infection. On 07/23/2026 at 09:45 AM, observation revealed R1 lay in his bed on his right side. The room was dark, with no lights on, and the curtains were shut. R1's mouth was full of thick grey mucus. R1 had oxygen on via a nasal cannula. The oxygen tubing lay on the floor of the room. The oxygen concentrator was dirty, with dried nutritional formula on its exterior. The oxygen concentrator humidifier bottle contained no distilled water and had a date of 07/02/2026. The tubing which connected the humidifier to the oxygen concentrator was dated 07/02/2026. The oxygen concentrator filter was filthy with thick grey dust and dirt. On 07/23/2026 at 11:45 AM, Licensed Nurse (LN) G and Administrative Nurse D demonstrated the correct way to perform a G-tube feeding with R1. The surveyor pointed out the tubing on the floor, the empty oxygen humidifier, the unclean condition of the oxygen concentrator, and the dates on the oxygen supplies. 2. R2's EMR documented R2 had diagnoses of asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), respiratory failure, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and pneumonia. The Annual MDS, dated 06/17/2026, documented R2 had a BIMS of 15, which indicated intact cognition. The MDS documented R2 required substantial staff assistance to dependence on staff for most of her ADLs. The MDS lacked documentation of oxygen use. The Functional Abilities CAA, dated 06/17/2026, documented R2 received skilled services because of a right hip dislocation with removal of the right hip. The CAA documented R2 required maximum assistance up to dependent care for ADLs. R2's Care Plan, dated 04/21/2025, documented R2 required continuous oxygen and directed staff to change oxygen tubing and rinse the filter weekly. The care plan lacked any direction regarding keeping the oxygen tubing off the floor. The Infection Note, dated 07/07/2026, documented an infection control assessment was completed on R2 because of a lower respiratory infection (pneumonia). R2's Medication Administration Record (MAR), dated July 2026, documented R2 was prescribed Levaquin 500 milligrams by mouth daily for a lower respiratory infection. On 07/23/2026 at 12:30 PM, observation revealed R2 being wheeled in a wheelchair to her room. R2's oxygen was on a portable oxygen canister. In R2's room, the oxygen concentrator R2 used for continuous oxygen revealed there was no filter in R2's oxygen concentrator. Grey dust could be seen in the holes that should have been covered by a filter. The oxygen concentrator humidifier and the tubing from the humidifier to the oxygen concentrator had a date of 07/02/2026. 3. R3's EMR documented R3 had diagnoses of COPD and respiratory failure with hypoxia and hypercapnia. The End of Skilled Care MDS, dated 07/17/2026, documented R3 had a BIMS score of 15, which indicated intact cognition. The MDS documented R3 was dependent with all her ADLs. The MDS documented R3 was on continuous oxygen. The Functional Abilities CAA, dated 04/05/2026, documented R3 had been readmitted to the facility for acute on chronic COPD with respiratory failure. The CAA documented R3 was dependent on staff for all cares but could feed herself. The CAA documented R3 was a full lift due to immobility and deconditioning. R3's Care Plan, dated 05/10/2021, documented R3 used supplemental oxygen. The care plan directed staff to change the oxygen tubing and rinse the concentrator filter weekly on Wednesdays. The care plan lacked direction regarding keeping oxygen tubing off the floor. The Health Status Note, dated 07/08/2026, documented R3 had returned from the emergency room with a diagnosis of exacerbation of COPD and pneumonia. New orders were received for doxycycline (antibiotic) 100 milligrams for seven days and cefdinir (antibiotic) 300 milligrams for 7 days. The Skilled Note, dated 07/13/2026, documented R3 had labored breathing with shortness of breath. Head of the bed elevated to 90 degrees. R3 currently on antibiotics for pneumonia. On 07/23/2026 at 11:30 AM, observation revealed R3 sat in a wheelchair (continued on next page)		

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	guidelines but did not do so. The facility's undated Oxygen Concentrator Policy documented the purpose of the policy was to establish responsibilities for the care and use of oxygen concentrators. The documented nursing would change oxygen tubing and mask/cannula weekly and as needed as it became soiled or contaminated, and nursing would change the humidifier bottle when empty, every seventy-two hours, or as recommended by the manufacturer. The facility's undated Infection Control Policy documented the facility would provide a safe, sanitary, and comfortable environment to help prevent the development and transmission of communicable diseases and infections as per accepted national standards and guidelines. The policy documented all reusable items and equipment requiring special cleaning, disinfection, or sterilization shall be cleaned in accordance with the facility's current procedures governing the cleaning and sterilization of soiled or contaminated equipment. Single-use disposable equipment must be discarded after use.		

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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. Based on record review, observation, and interview, the facility failed to ensure residents received the required assistance with activities of daily living (ADL) when staff failed to provide Resident (R) 1 with the necessary oral care to keep R1's mouth free from mucus. Findings included:- R1's Electronic Medical Record (EMR) documented R1 had diagnoses of quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), muscle wasting, cognitive impairment, cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness) pneumonia (an infection in the lungs), respiratory failure (when the lungs cannot send enough oxygen to the blood) with hypercapnia (a condition that occurs when there is too much carbon dioxide in the blood) and hypoxia (inadequate supply of oxygen), and traumatic brain injury (TBI-an injury to the brain caused by external forces). R1's Annual Minimum Data Set (MDS), dated 07/10/26, documented R1 had a Brief Interview for Mental Status (BIMS) score of 10, which indicated moderately impaired cognition. The MDS documented R1 had difficulty communicating some words or finishing thoughts and missed some part or intent of a message but could understand most of a conversation. The MDS documented R1 had impairment of both sides of his upper and lower extremities. The MDS documented R1 was dependent on staff for all ADLs. The MDS documented R1 received oxygen therapy and required a non-invasive mechanical ventilator (CPAP- a ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). The Cognitive Loss/Dementia Care Area Assessment (CAA), dated 07/10/26, documented R1 had diagnoses of TBI, communication deficit, and cognitive impairment. The CAA documented R1 had poor short-term memory and poor decision-making skills. The CAA documented activities were provided to keep R1 engaged. The Functional Abilities CAA, dated 07/10/26, documented R1 was dependent on staff for all care, had an indwelling catheter (a flexible tube inserted through a narrow opening into a body cavity, particularly the bladder, for removing fluid), and a colostomy (surgical creation of an artificial opening on the stomach wall to excrete feces from the body). R1 had difficulty swallowing and had a gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) for nutrition. R1's Care Plan, initiated on 04/30/2017, documented R1 was dependent on staff for oral care and R1 would be free from infection, pain, or bleeding. The care plan directed staff to assist R1 with oral care twice daily and as needed. The Health Status Note, dated 07/16/2026, documented a chest X-ray had been performed on R1, and the results were bilateral poorly defined infiltrates (pneumonia), and an antibiotic, Levaquin 500 milligrams, was ordered daily via g-tube. The Infection Note, dated 07/16/2023, documented an infection control assessment had been completed because R1 had a lower respiratory infection. On 07/23/2026 at 09:45 AM, observation revealed R1 lay in his bed on his right side. The room was dark, with no lights on, and the curtains were shut. R1's mouth was full of thick grey mucus. On 07/23/2026 at 11:45 AM, Licensed Nurse (LN) G and Administrative Nurse D demonstrated the correct way to perform a G-tube feeding with R1. Neither LN G nor Administrative Nurse D provided R1 with oral care at this time. R1 continued to have thick mucus in his mouth. On 07/23/2026 at 01:00 PM, observation revealed R1 sat in his geri-chair in the common area and watched TV. Blood could be seen in R1's mouth and around his lips. There was no mucus in R1's mouth. R1 said, Ya, when asked if his mouth hurt. On 07/23/2026 at 02:00 PM, Administrative Nurse D verified oral care should have been completed for R1 that morning. The facility's undated Oral Care Policy documented it was the practice of the facility to provide oral care to residents to prevent and control plaque-associated oral disease.		