STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175411	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Easton Health Care Center	515 Dawson Easton, KS 66020

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 0686 Level of Harm - Actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 39 residents. The sample included 12 residents, with one resident reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction). Based on observations, record review, and interview, the facility failed to prevent the development of an avoidable stage three (full-thickness pressure injury extending through the skin into the tissue below) pressure ulcer on Resident (R) 25's left heel.Findings included:- R25's Electronic Medical Record (EMR) documented diagnoses of embolism (an obstruction in a blood vessel due to a blood clot or other foreign matter that gets stuck while traveling through the bloodstream) and thrombosis (a clot that develops within a blood vessel) of the vein, polyneuropathy, and pressure ulcer of the left heel stage three.R25's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of four, which indicated severely impaired cognition. R25 had impairment in both lower extremities. R25 was dependent on staff for his cares. R25 was at risk for pressure ulcers but currently had no unhealed pressure wounds. R25 had no skin or ulcer/injury treatments in place.R25's Pressure Ulcer/Injury Care Area Assessment (CAA) dated 11/05/25 documented R25 was at risk for development of pressure injuries due to decreased mobility and prolonged periods in his bed or chair. Contributing factors may include impaired sensory perception, friction/shear, and/or incontinence. Skin assessments revealed no open areas at this time; however, his skin was fragile and required close monitoring. R25's nutrition and hydration status were monitored as these are essential to skin integrity and healing.R25's Care Plan, revised on 02/24/25, documented R25 had a pressure-reducing mattress and a cushion in his wheelchair. R25 was able to offload while up in his recliner. R25 was able to assist with turning and repositioning while in bed with the use of bed canes. The Care Plan directed staff to complete a Braden Scale quarterly and as needed to identify the risk for skin issues. The Care Plan directed staff that nursing would complete a weekly skin assessment, and staff would monitor his skin with all cares. The initial Care Plan lacked interventions to reduce pressure to the heels and elbows. The Care Plan lacked staff direction on treatment and cares in place for R25's Stage three pressure ulcer on his left heel.R25's EMR Orders tab documented a physician's order dated 01/27/25 to clean the left heel with wound cleanser and pat dry, cut AquaRite (a highly absorbent, non-woven wound dressing made from sodium carboxymethyl cellulose and cellulose fibers, used for moderately to heavily exuding wounds like ulcers) to fit the wound, and apply it to the wound, then cover with a dry dressing.R25's EMR Orders tab documented a physician's order dated 02/22/25 to clean left heel with wound cleanser and pat dry, apply gentamycin (medicated cream used for bacterial infections) and Santyl (prescription medication used to remove dead or damaged tissue from chronic skin ulcers and severe burns), cut calcium alginate (highly absorbent dressing) to fit wound and apply to wound, cover with a dry dressing every shift and as needed for pressure ulcer and deep tissue injury to left heel. This order was discontinued on 05/07/25.R25's EMR Orders tab documented a physician's order 05/07/25 to clean the open area on the left heel with hypochlorous acid wound cleanser (a natural disinfectant used in skin care for wound healing), pat dry, cut Prisma collagen (wound treatment used to absorb fluid and provide an antibacterial barrier) to fit the wound (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 0686 Level of Harm - Actual harm Residents Affected - Few	bed, and apply. Cover with an abdominal (ABD) pad, secure with kerlix (gauze bandage) and tape every day shift and as needed for pressure ulcer of the left heel. This order was discontinued on 08/21/25.R25's Braden Scale for Predicting Pressure Sore Risk (evidence-based assessment tool used widely to predict the risk of developing pressure injuries) at admission dated 09/06/24 documented a score of 21, which indicated low risk.R25's Weekly Skin Evaluation dated 01/15/25 at 12:15 AM documented discoloration noted on all extremities; left lateral leg bruising. Edema (swelling) in the bilateral lower extremities.R25's Weekly Skin Evaluation dated 01/27/25 at 08:04 AM documented new open areas to the left heel- a deep tissue injury measuring 6 centimeters (cm) by 4.5 cm and a Stage three pressure ulcer measuring 5 cm in length by 4 cm in width by 0.2 cm in depth. A treatment order was received from the physician.R25's Weekly Pressure Injury Skin Report dated 01/27/25 at 10:08 PM, documented a Stage three pressure wound to the left heel that measured 5 cm in length, 4 cm in width, and 0.2 cm in depth. The wound had moderate serosanguineous (semi-thick blood-tinged drainage) exudate (a fluid that leaks out of body vessels and tissues), with maceration (softening and breaking down of skin because of prolonged exposure to moisture, such as sweat, urine, or feces) and discoloration to the surrounding skin. Interventions put in place were for wound treatments and a positioning device. The wound treatment was to clean the left heel with wound cleanser and pat dry, cut AquaRite to fit the wound, and then apply it to the wound bed, then cover with a dry dressing, change daily and as needed for soiling. There was a deep tissue injury to the left heel that measured 6 cm in length and 4.5 cm in width.R25's Misc tab had a scanned physician's visit documentation from 02/24/25 documenting the resident seen and examined for a regulatory visit. R25 was lying in bed. It was almost 09:00 AM, and R25 was asked if he was eating breakfast. R25 stated no, that he was not hungry, but he planned on getting up right now. R25 was asked about his mood, and he stated it was great. R25 has a wheelchair for ambulation. The pharmacy recommended a reduction in his trazodone (medication used to treat depression), and it would be done. R25 followed commands appropriately and was in no apparent distress. The residents' medications were reviewed. The case was discussed with the staff, and R25 would continue to be monitored. The physician's visit did not mention anything regarding R25's left heel wound.The Skin Check progress note dated 08/21/25 at 06:48 PM documented R25's Skin was warm and dry, skin color within normal limits (WNL), and turgor was normal. R25's foot evaluation was completed, and the pressure ulcer/injury was resolved, wound healed, and or closed.Review of R25's EMR revealed that a nurse assessment of R25's skin was documented weekly from 08/21/25 to 12/06/25.R25's Braden Scale for Predicting Pressure Sore Risk assessment dated [DATE] documented a score of 15, which indicated he was at risk of pressure sore development.The Skin Check progress note dated 12/06/25 at 06:20 AM documented: Skin: Skin warm & dry, skin color WNL, and turgor is normal. R25 did not have an external device, and the left heel had a scabbed area wound acquired in-house.The Skin Check progress note dated 12/11/25 at 02:47 PM documented the skin issue had not been evaluated. The left heel has a scabbed area, a wound acquired in-house. R25 had a new skin issue to left heel with a pressure ulcer/injury. Progress: new wound. Pressure ulcer staging: Stage three Pressure ulcer/injury - full-thickness skin loss, a wound acquired in-house with the exact date of 12/11/25. No signs and symptoms of infection, not painful. Measurements: 1.55 cm in length by 1.48 cm in width by 0.3 cm in depth. There was no undermining, no tunneling, the area was normal in color, and no swelling or edema.R25's Order Summary Report documented a physician's order dated 12/16/25 to clean the left heel with wound cleanser and pat dry, apply a nickel-thick layer to the wound bed, cut calcium alginate (highly absorbent wound dressing used for wound healing) to fit the wound bed, and apply, cover with a dry dressing. Every day shift related to pressure ulcer of the left heel, Stage three.On 01/12/26 at 11:15 AM, R25 sat in his wheelchair in the hallway and was self-propelling to the dining room.On 01/13/26 at 11:40 AM, Licensed Nurse (LN) G stated she only worked occasionally and really did not update the care plans, but she would expect R25's care plan to address or have interventions in place for wound prevention. LN G stated most residents should have all the (continued on next page)

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F 0686 Level of Harm - Actual harm Residents Affected - Few	normal interventions in place, like the barrier cream used and floating the heels.On 01/13/26 at 09:30 AM Administrative Nurse D stated she did her best to make sure treatments and skin care interventions had been updated in the care plans. Administrative Nurse D stated she had done the weekly skin assessments on him but looking at his care plan, she clearly dropped the ball on getting his treatment and wound information from the previous heel wound or the current wound put on his care plan.The facility's Pressure Injury Prevention Interventions Policy policy dated 05/18/24 documented the purpose of pressure injury interventions was to prevent the formation of avoidable pressure Injuries and to promote healing of existing pressure injuries. It is the policy of this facility to implement evidence-based Interventions for all residents who are assessed at risk or who have a pressure Injury present. Individualized interventions would address specific factors identified in the resident's risk assessment, skin assessment, and any pressure injury assessment. Preventive Skin Care included: inspecting skin while providing care, paying close attention to bony prominences. Inspect the skin underneath medical devices at least twice [NAME]. Keep the skin clean and dry underneath. Adjust devices as needed for proper fit. Avoid positioning the resident on an area of redness whenever possible. Keep the skin clean and dry. Manage incontinence with absorptive products. Check every two hours, and provide perineal care as needed after incontinent episodes. Protect skin from exposure to excessive moisture with barrier products. Moisturize dry skin. Use positioning devices or folded linens to keep body surfaces from rubbing against one another. Consider use of prophylactic dressings for prevention of sacral and heel pressure injuries. Avoid vigorous massage over bony prominences.The Wound Treatment Management Policy dated 05/03/24, documented the purpose of wound treatments was to promote wound healing of various types of wounds, It Is the policy of this facility to provide evidence-based treatments in accordance with current standards of practice and. physician orders. Wound treatments will be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. In the absence of treatment orders, the licensed nurse will notify physician to obtain treatment orders. This may be the treatment nurse, or the assigned licensed nurse in the absence of the treatment nurse. Treatments will be documented on the Treatment Administration Record or in the electronic health record. The effectiveness of treatments will be monitored through ongoing assessment of the wound. Considerations for needed modifications include: Lack of progression towards healing; Changes in the characteristics of the wound; Changes in the resident's goals and preferences, such as at end-of-life or in accordance with his/her rights.

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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 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when the facility failed to ensure Enhanced Barrier Precautions (EBP-infection control interventions designed to reduce transmission of resistant organism which employ targeted gown and glove use during high contact care) were used for Resident (R) 4, who had a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder), failed to handle and transport soiled linen in a safe and sanitary manner, failed to ensure R4's catheter bag did not drag on the floor while in his wheelchair and bed. The facility failed to ensure staff performed appropriate glove changing and hand hygiene while performing personal care for R4 and failed to disinfect a mattress after changing soiled linens.Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of retention of urine (the inability to completely empty the bladder), urinary tract infection (UTI- an infection in any part of the urinary system), and benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow).R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had intact cognition. R4 was dependent upon staff assistance for toileting hygiene, lower body dressing, and substantial assistance with personal hygiene. R4 further required partial staff assistance with mobility. The MDS documented R4 had a urinary catheter and had a UTI during the lookback period.R4's 10/19/25 Care Plan included the following interventions:10/26/25 - Encourage the resident to use the bell to call for assistance; he required moderate to maximum assistance from one staff member for personal hygiene.11/08/25 - R4 had an indwelling suprapubic catheter and positioned the catheter bag and tubing below the level of the bladder. R4 frequently placed his catheter bag on the floor and had been educated on the risk associated with doing this. Monitor and document output as per facility policy, monitor for signs and symptoms of discomfort, urination, and frequency. Monitor and document for pain or discomfort due to the catheter, monitor, document, and record signs and symptoms of a UTI.The care plan lacked documentation and direction to staff on the use of personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) to be worn while cares were provided.On 01/11/26 at 09:20 AM, R4 sat on the side of the bed. He wore a shirt and an incontinence brief. R4's bottom sheet was very soiled with bowel movement. R4 stated that he had sat in the bowel for a while and had asked staff to clean him up. R4 stated he was told that they would clean him up after breakfast when they got him up and into his wheelchair, so he tried to clean himself up. R4 stated that he had a catheter and lifted the apron of his belly (a fold of excess skin that hangs from the lower abdomen). Observation revealed a reddened catheter insertion site with yellow drainage. There was a wadded-up, soiled 4x4 gauze (a woven or non-woven fabric used in wound care for absorbing fluids) dressing between the folds of his abdomen. Continued observation revealed Certified Nurse Aide (CNA) M came into the room and stated they were getting ready to get him up. When asked if he was aware of the soiled linens, he stated, No, he was just helping the other CNA. CNA M left to go get clean linens and came back into the room with CNA M. CNA M pushed the full mechanical lift into the room; she wore a gown and gloves, but CNA M only had on gloves and did not shut R4's room door. The CNAs assisted R4 to lie down in the bed. CNA N bent down to empty the catheter bag, and when she was done, laid the bag on the floor. While CNA N drained the catheter bag, CNA M started to take off the bed linens. R4 rolled to the left side, and CNA M opened the incontinent brief and used wipes to clean the bowel off the resident and stated, You are having another bowel movement. And continued to clean the resident. CNA M had R4 roll onto his back, and she wiped under his abdomen apron and did not change her gloves. CNA N had R4 roll to the right side, and there was bright red blood on the sheet and brief. When asked where the blood came from, CNA M stated, He has hemorrhoids (swollen, (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	inflamed veins in the lower rectum or around the anus). CNA M removed the rest of the soiled sheets from the bed and threw them onto the floor. R4 rolled onto his back, and the clean brief was secured. CNA N placed the catheter bag on the bed and started to assist R4 with a clean pair of sweatpants. R4 rolled to his left side, and CNA M put the mechanical lift sling under him, with the same soiled gloves. They attached the sling to the lift, transferred him into his wheelchair, and hooked the catheter bag under his wheelchair. CNA M picked up the soiled sheets from the floor and carried them unbagged down the hall. CNA N took off R4's shirt and set it on the bed, then assisted him with a clean shirt. CNA M came back into the room and took the shirt and wiped off R4's mattress, laid the dirty shirt on his bedside table, and put new linens on the bed with the same soiled gloves. When asked why CNA N had on a gown, and CNA M didn't, she stated it was personal preference and did not know that CNA M was supposed to wear a gown. R4 asked the CNAs for soapy water and a rag to wash his hands, and they did not get him any. CNA M took R4 down to the dining room. On 01/12/26 at 03:00 PM, Licensed Nurse (LN) G went into R4's room, took off his socks, used wound cleanser to wash his legs, and applied A & D ointment to his legs and feet. LN G did not have a gown on, just gloves. LN G stated she had forgotten to put one on. R4's shirt was stained at the area of the catheter site. LN G lifted his shirt and his abdomen, and there was thick, yellow, stringy discharge at the site. LN G stated she would have staff lay R4 into bed, and she would look at the site. Further observation revealed four gowned and gloved CNAs in R4's room to assist with the transfer from his wheelchair and into his bed. The mechanical lift's battery was dead, so they had to go get a charged battery. R4 was transferred into his bed, and his sweatpants were removed. CNA M had R4 roll to his left side. She opened the brief and provided incontinence care. CNA N had him roll onto his back and cleaned the insertion site. CNA M rolled R4 to his right side, and there was bright red blood on the brief. CNA N and CNA M continued to clean R4 and put the clean brief on and covered him up. Further observation revealed LN G and LN H came into the room and looked at R4's catheter insertion site, and R4 stated, it's been oozing pus (a thick yellowish or greenish opaque liquid produced in infected tissue consisting of white blood cells and bacteria with tissue debris). LN G stated, it looked fine. LN H opened up R4's brief to see where the blood was coming from, and they were able to see that he had 2 areas on his scrotum (the sac of skin and muscle located outside the lower body that holds and protects the testicles). LN H stated it looked like it was from being pinched. LN H measured the superior open area at 8.2 centimeters (cm) by 0.7 cm and the inferior open area at 0.9 cm by 0.6 cm. LN H stated she would contact the physician about the areas and his catheter insertion site.On 01/12/26 at 03:30 PM, Administrative Nurse D stated, she would contact the physician about the concerns and get a treatment order. Administrative Nurse D stated staff are to wear the gown and gloves when providing cares for R4.On 01/13/25 at 03:40 PM, Administrative Nurse D stated R4 has a history of noncompliance with cares and would lay his catheter bag on the floor. She stated staff should have changed their gloves after cares and before getting him dressed. The CNA should have bagged the linens and taken them to the laundry room and should not have used his clothing to wipe off the bed. She stated she had already started education regarding the PPE and would also do infection control education.The facility's Handling Clean and Dirty Linen Policy, dated 06/24/26, documented that all linen should be handled using standard precautions and treated as potentially contaminated. Linens may require special handling is visibly soiled with blood and large amounts of bodily fluids. Used or soiled linen shall be collected at the bedside and placed in a linen bag or designated lined receptacle. When the task is complete, the bag shall be closed securely and placed in the soiled utility room. Soiled linen shall not be kept in the resident's room or bathroom. If linen is heavily soiled, wet and/or presents a risk of leakage or soaking through, the linen shall be double bagged.The facility's Enhanced Barrier Precautions (EBP) policy, dated 05/18/24, documented EBP must be used for high contact resident care activities or residents with indwelling medical devices including, but not limited to, central line, urinary catheters, and feeding tubes.The facility's Standard Precautions-Infection Control policy, dated 05/14/24, documented all staff were to assume that all (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	residents were potentially infected or colonized with an organism that could be transmitted during the course of providing resident care services. Therefore, all staff shall adhere to standard precautions to prevent the spread of infection to residents, staff and visitors. Staff shall perform hand hygiene after contact with contaminated objects.

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F 0583 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Keep residents' personal and medical records private and confidential. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to promote dignity and respect for one resident, Resident (R) 4, when staff did not close the door to his room before providing personal cares.Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of retention of urine (the inability to completely empty the bladder), urinary tract infection (UTI- an infection in any part of the urinary system), and benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow).R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented R4 had a Brief Interview for Mental Status Score (BIMS) of 15, which indicated intact cognition. R4 was dependent upon staff assistance for toileting hygiene, lower body dressing, and substantial assistance with personal hygiene. R4 further required partial staff assistance with mobility. The MDS documented R4 had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) and had a UTI during the lookback period.R4's 10/19/25 Care Plan included the following interventions:10/26/25 - Directed staff to encourage the resident to use the bell to call for assistance. R4 required moderate-to-maximum assistance from one staff member for personal hygiene.11/08/25 - Documented R4 had an indwelling suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and positioned the catheter bag and tubing below the level of the bladder. R4 frequently placed his catheter bag on the floor and had been educated on the risk associated with doing this. Monitor and document output as per facility policy, monitor for signs and symptoms of discomfort, urination, and frequency. Monitor and document for pain or discomfort due to the catheter, monitor, document, and record signs and symptoms of a UTI.R4's Care Plan lacked documentation and direction to staff on the use of personal protective equipment (PPE- gowns, face shields, and/or eyeglasses/goggles, and gloves) to be worn while cares were provided. On 01/11/26 at 09:20 AM, R4 sat on the side of the bed. He wore a shirt and an incontinence brief. R4's bottom sheet was very soiled with bowel movement. R4 stated that he had sat in the bowel for a while and had asked staff to Clean him up. R4 stated he was told that they would clean him up after breakfast when they got him up and into his wheelchair, so he tried to clean himself up. Continued observation revealed Certified Nurse Aide (CNA) M came into the room and stated they were getting ready to get him up. CNA M left to get clean linens and came back into the room with CNA N. CNA N pushed the full mechanical lift into the room, and did not shut R4's room door. The CNAs assisted R4 to lie down in the bed. CNA N bent down to empty the catheter bag, and when she was done, laid the bag on the floor. While CNA N drained the catheter bag, CNA M started taking off the bed linens. R4 rolled to the left side, and CNA M opened the incontinent brief and used wipes to clean the bowel off the resident and stated, You are having another bowel movement. And continued to clean the resident. CNA M removed the rest of the soiled sheets from the bed and threw them onto the floor. R4 rolled onto his back, and the clean brief was secured. CNA N placed the catheter bag on the bed and started to assist R4 with a clean pair of sweatpants. R4 rolled to his left side, and CNA M put the mechanical lift sling under him. They attached the sling to the lift and transferred him into his wheelchair, then hooked the catheter bag under his wheelchair. CNA N took off R4's shirt, set it on the bed, then assisted him with a clean shirt. On 01/13/25 at 02:30 PM, Administrative Nurse D stated staff should have shut the resident's door before providing cares and any resident in a shared room, staff were to pull the privacy curtain.The facility's Promoting/Maintaining Resident Dignity policy, dated 09/21/25, documented it was the practice of the facility to protect and promote resident rights and treat each resident with respect and dignity, as well as care for each resident in a manner and in an environment that maintained or enhanced the resident's quality of life by recognizing each resident's individuality. All staff members are involved in providing care to residents to promote and maintain resident dignity and resident rights. Staff are to maintain resident privacy.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 39 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure R4's care plan had been revised to include enhanced barrier precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact cares) that needed to be worn during staff cares of his supra pubic catheter (urinary bladder catheter inserted through the abdomen into the bladder).Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of retention of urine (the inability to completely empty the bladder), urinary tract infection (UTI- an infection in any part of the urinary system), and benign prostatic hyperplasia (BPH -non-cancerous enlargement of the prostate which can lead to interference with urine flow).R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented R4 had a Brief Interview for Mental Status Score (BIMS) of 15, which signified intact cognition. R4 was dependent upon staff assistance for toileting hygiene, lower body dressing, and substantial assistance with personal hygiene. R4 further required partial staff assistance with mobility. The MDS documented R4 had a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) and had a UTI during the lookback period.R4's 10/19/25 Care Plan included the following interventions:10/26/25 - Encourage the resident to use the bell to call for assistance; he required moderate-to-maximum assistance from one staff member for personal hygiene.11/08/25 - R4 had an indwelling suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and positioned the catheter bag and tubing below the level of the bladder. R4 frequently placed his catheter bag on the floor and had been educated on the risk associated with doing this. Monitor and document output as per facility policy, monitor for signs and symptoms of discomfort, urination, and frequency. Monitor and document for pain or discomfort due to the catheter, monitor, document, and record signs and symptoms of a UTI. R4's Care Plan lacked documentation and direction to staff on the use of personal protective equipment (PPE-gowns, face shields, and/or eyeglasses/goggles, and gloves) to be worn while cares were provided.On 01/11/26 at 09:20 AM, R4 sat on the side of the bed. He wore a shirt and an incontinence brief. R4's bottom sheet was very soiled with bowel movement. R4 stated that he had sat in the bowel for a while and had asked staff to clean him up. R4 stated he was told that they would clean him up after breakfast when they got him up and into his wheelchair, so he tried to clean himself up. R4 stated that he had a catheter and lifted the apron of his belly (a fold of excess skin that hangs from the lower abdomen). Observation revealed a reddened catheter insertion site with yellow drainage. There was a wadded-up, soiled 4x4 gauze (a woven or non-woven fabric used in wound care for absorbing fluids) dressing between the folds of his abdomen. Continued observation revealed Certified Nurse Aide (CNA) M came into the room and stated they were getting ready to get him up. When asked if he was aware of the soiled linens, he stated, No, he was just helping the other CNA. CNA M left to go get clean linens and came back into the room with CNA M. CNA M pushed the full mechanical lift into the room; she wore a gown and gloves, but CNA M only had on gloves and did not shut R4's room door. The CNAs assisted R4 to lie down in the bed. CNA N bent down to empty the catheter bag, and when she was done, laid the bag on the floor. While CNA N drained the catheter bag, CNA M started to take off the bed linens. R4 rolled to the left side, and CNA M opened the incontinent brief and used wipes to clean the bowel off the resident and stated, You are having another bowel movement. And continued to clean the resident. CNA M had R4 roll onto his back, and she wiped under his abdomen apron and did not change her gloves. CNA N had R4 roll to the right side, and there was bright red blood on the sheet and brief. When asked where the blood came from, CNA M stated, He has hemorrhoids (swollen, inflamed veins in the lower rectum or around the anus). CNA M removed the rest of the soiled sheets from the bed and threw them onto the floor. R4 rolled onto his back, and the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175411	A. Building B. Wing	01/13/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Easton Health Care Center	515 Dawson Easton, KS 66020

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	clean brief was secured. CNA N placed the catheter bag on the bed and started to assist R4 with a clean pair of sweatpants. R4 rolled to his left side, and CNA M put the mechanical lift sling under him, with the same soiled gloves. They attached the sling to the lift, transferred him into his wheelchair, and hooked the catheter bag under his wheelchair. CNA M picked up the soiled sheets from the floor and carried them unbagged down the hall. CNA N took off R4's shirt and set it on the bed, then assisted him with a clean shirt. CNA M came back into the room and took the shirt, wiped off R4's mattress, laid the dirty shirt on his bedside table, and put new linens on the bed with the same soiled gloves. When asked why CNA N had on a gown, and CNA M didn't, she stated it was personal preference and did not know that CNA M was supposed to wear a gown. R4 asked the CNAs for soapy water and a rag to wash his hands, and they did not get him any. CNA M took R4 down to the dining room. On 01/13/25 at 02:30 PM, Administrative Nurse D stated R4's EBP status should be on the care plan, and she would make sure it was updated.The facility's Comprehensive Care Plan policy, dated 10/31/24, documented that the facility develops and implement comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment.

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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 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to prevent two superficial open areas on Resident (R) 4's scrotum (the sac of skin and muscle located outside the lower body that holds and protects the testicles).Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of chronic osteomyelitis (local or generalized infection of the bone and bone marrow), venous insufficiency (slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin was made, or the body cannot respond to the insulin) type two.R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented R4 had intact cognition. R4 was dependent upon staff assistance for toileting hygiene, lower body dressing, and substantial assistance with personal hygiene. R4 further required partial staff assistance with mobility. The MDS documented R4 was at risk for breakdown, received nonsterile dressings, and ointments.R4's 10/19/25 Care Plan included the following interventions:10/26/25 - Directed nursing staff to assess, record, and monitor wound healing. Measure length, width, and depth where possible. Assess and document the status of wound perimeter, wound bed, and healing progress. Report improvements and declines to the physician. Educate the resident/family/caregivers as to causes of skin breakdown, including transfer, positioning requirements, the importance of taking care during ambulation, mobility, good nutrition, and frequent repositioning. Follow facility policies/protocols for the prevention/treatment of skin breakdown. If the resident refuses treatment, confer with the resident, team, and family to determine why and try alternative methods to gain compliance. Document alternative methods.On 01/11/26 at 09:20 AM, during incontinence care Certified Nurse Aide (CNA) N had R4 roll to the right side and there was bright red blood on the sheet and brief. When asked where the blood came from, CNA M stated, He has hemorrhoids (swollen, inflamed veins in the lower rectum or around the anus). R4 rolled onto his back and the clean brief was secured.On 01/12/25 at 03:00 PM, during incontinence care, CNA M rolled R4 to his right side and there was bright red blood on the brief. CNA P left the room to get a nurse. CNA N and CNA M continued to clean R4 and put the clean brief on and covered him up. Further observation revealed LN G and LN H came into the room to assess R4. LN H opened up R4's brief to see where the blood was coming from, and they were able to see that R4 had two areas on his scrotum (the sac of skin and muscle located outside the lower body that holds and protects the testicles). LN H stated it looked like it was from being pinched. LN H measured the superior open area at 8.2 centimeters (cm) by 0.7 cm and the inferior open area at 0.9 cm by 0.6 cm. LN H stated she would contact the physician about the areas and would see if they needed to provide larger incontinence briefs for R4.On 01/12/26 at 03:30 PM, Administrative Nurse D stated she would contact the physician about the concerns and get a treatment order. Administrative Nurse D stated she would try to figure out how to ensure his skin was protected so that he was not getting pinched.The facility's Wound Treatment Management Policy, dated 05/03/24, documented the facility provided evidence-based treatments in accordance with current standards of practice and physician orders. Wound treatments would be provided in accordance with physician orders, including the cleansing method, type of dressing, and frequency of dressing change. Treatment decisions would be based on pressure, surgical, incidental, and atypical. Due to the unique needs and situations of individuals, the guidelines may not be appropriate for use in all circumstances. The facility would follow specific physician orders for providing wound care.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to provide services consistent with the standard of care for one resident, Resident (R) 4, reviewed for urinary catheter (a tube inserted into the bladder to drain urine) or urinary tract infection (UTI- an infection in any part of the urinary system).Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of retention of urine (the inability to completely empty the bladder), UTI, and benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow).R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented R4 had intact cognition. R4 was dependent upon staff assistance for toileting hygiene, lower body dressing, and substantial assistance with personal hygiene. R4 further required partial staff assistance with mobility. The MDS documented R4 had a urinary catheter and had a UTI during the lookback period.R4's 10/19/25 Care Plan included the following interventions:10/26/25 - Encourage the resident to use the bell to call for assistance; he required moderate-to-maximum assistance from one staff member for personal hygiene.11/08/25 - R4 had an indwelling suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) and positioned the catheter bag and tubing below the level of the bladder. R4 frequently placed his catheter bag on the floor and had been educated on the risk associated with doing this. Monitor and document output as per facility policy, monitor for signs and symptoms of discomfort, urination, and frequency. Monitor and document for pain or discomfort due to the catheter, monitor, document, and record signs and symptoms of a UTI.A review of R4's clinical record revealed the R4 had a positive UTI on 11/06/25 and 12/31/25.The Physician's Order dated 11/26/25 directed staff to administer meropenem (a powerful, broad-spectrum antibiotic used to treat serious bacterial infections), 1 gram (gm), intravenously, every eight hours for seven days.The Physician's Order dated 12/31/25 directed staff to administer Macrobid (antibiotic to treat UTIs), 100 milligrams (mg), by mouth, twice a day for ten days.The Physician's Order dated 10/19/25 directed staff to change the suprapubic catheter anchor every night shift, every seven days.The Physician's Order dated 10/19/25 directed staff to cleanse the suprapubic catheter with soap and water every day and night.The Physician's Order dated 10/26/25 directed staff to change the suprapubic catheter collection bag every night shift, every seven days, for the diagnosis of retention of urine.The Physician's Order dated 11/25/25 directed staff to change the suprapubic catheter, size 18 French with 30 milliliter (ml) balloon every 28 days for the diagnosis of retention of urine.On 01/11/26 at 09:20 AM, R4 sat on the side of the bed. He wore a shirt and an incontinence brief. R4 stated that he had a catheter and lifted the apron of his belly (a fold of excess skin and at that hangs from the lower abdomen). Observation revealed a reddened catheter insertion site with yellow drainage. There was a wadded-up, soiled 4x4 gauze (a woven or non-woven fabric used in wound care for absorbing fluids) dressing between the folds of his abdomen. The Certified Nurse Aide (CNA') assisted R4 to lie down in the bed. CNA N bent down to empty the catheter bag and did not clean the drainage valve. When she was done, laid the bag on the floor and did not change her gloves. R4 rolled to the left side, and CNA M opened the incontinent brief and used wipes to clean the bowel off the resident, and stated, You are having another bowel movement, and continued to clean the resident. CNA M had R4 roll onto his back, and she wiped under his abdomen apron, with soiled gloves. R4 rolled onto his back and the clean brief was secured. CNA N placed the catheter bag on the bed and started to assist R4 with a clean pair of sweatpants. R4 rolled to his left side and CNA M put the mechanical lift sling under him, with same soiled gloves. They attached the sling to the lift and transferred him into his wheelchair and hooked the catheter bag under his wheelchair. CNA M took R4 down to the dining room. On 01/12/26 at 03:00 PM, Licensed Nurse (LN) G went into R4's room, took off his socks, used wound cleanser to wash his (continued on next page)

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	legs, and applied A & D ointment to his legs and feet. LN G did not have a gown on, just gloves. LN G stated she had forgotten to put one on. R4's shirt was stained at the area of the catheter site. LN G lifted his shirt and his abdomen and there was thick, yellow, stringy discharge at the site. LN G stated, she would have staff lay R4 into bed and she would look at the site. Further observation revealed four gowned and gloved CNA's in R4's room to assist with the transfer from his wheelchair and into his bed. The mechanical lift's battery was dead, so they had to go get a charged battery. R4 was transferred into his bed, and his sweatpants removed. CNA M had R4 roll to his left side, she opened the brief and provided incontinence care. CNA N had him roll onto his back and cleaned the insertion site. CNA N and CNA M continued to clean R4 and put the clean brief on and covered him up. Further observation revealed LN G and LN H came into the room and looked at R4's catheter insertion site and R4 stated, it's been oozing pus (a thick yellowish or greenish opaque liquid produced in infected tissue consisting of white blood cells and bacteria with tissue debris). LN H stated she would contact the physician for treatment.On 01/11/26 at 09:30 AM, CNA N stated she should have changed her gloves before she helped him put on clean clothes.On 01/12/25 at 03:00 PM, LN H stated R4 had a habit of scratching everywhere and then touches his catheter site. The catheter site was cleaned every time they checked and changed his incontinence brief.On 01/12/25 at 02:30 PM, Administrative Nurse D stated R4 had a history of urinary tract infections and would put his catheter bag on the floor sometimes, but should not drag it on the floor. Administrative Nurse D further stated that she would contact the physician to get a treatment order for his catheter insertion site. Administrative Nurse D further stated staff should change their gloves when going from dirty to clean.The facility's Catheter Care policy, dated 06/26/24, documented the facility ensured that residents with indwelling catheters received appropriate catheter care and maintained their dignity when indwelling catheters were in use. Ensure the drainage bag was located below the level of the bladder to discourage backflow of urine. Perform hand hygiene when done.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 39 residents. The sample included 12 residents. Based on record review and interview, the facility failed to submit complete and accurate staffing information through the Payroll-Based Journal (PBJ) as required.Findings included: - The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Fiscal Year (YR) 2025 Quarter (Q) 1, Q2, Q3, and Q4 indicated excessively low weekend staffing.Review of the facility's Nursing Staff scheduled for the above quarters revealed adequate staffing on duty was provided.On 01/12/26 at 02:15 PM, Administrative Staff A stated the information for the PBJ was pulled in the corporate office from the time clock. Administrative Staff A stated they have not been short on the weekends and do not use agency. The Director of Nursing and herself do the schedule. They have gone through several different payroll programs so that may be what has caused this issue. The facility does weekend [NAME] staffing which means staff who work both Saturday and Sunday, 12 hours earn an extra eight hours on their check for working both days; however, if they call in, then they are not rewarded the eight hours. They also allow the full-time staff to pick their preferred days and utilize part-time or as-needed staff to fill in the gaps.The facility's Sufficient Staff Policy, dated 05/18/24, documented the facility provide sufficient staff with appropriate competencies and skill sets to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident. The facility's census, acuity, and diagnosis of the resident population would be considered based on the facility assessment. The facility was responsible for submitting timely and accurate staffing data through the CMS PBJ system