STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175417	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Frankfort Community Care Home	510 N Walnut Street Frankfort, KS 66427

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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility had a census of 27 residents. The sample included 12 residents, with three residents reviewed for the Center for Medicare and Medicaid Services (CMS) Beneficiary Liability notices. Based on the record review and interview, the facility failed to provide the CMS Form 10123, Advanced Beneficiary Notice (ABN), to the resident or their representative for Residents (R) 4. Findings included:- The Medicare ABN form informed the beneficiaries that Medicare may not pay for future skilled therapy and did not provide an estimated cost to continue their services. The form included options for the beneficiary to (1) receive specified services listed, and bill Medicare for an official decision on payment. I understand that if Medicare does not pay, I will be responsible for payment, but I can appeal to Medicare. (2) receive therapy listed, but do not bill Medicare, I am responsible for payment of services. (3) I do not want the listed services. This placed the residents at risk of uninformed decisions about their skilled services. The facility lacked documentation staff provided R4 (or their representative) the CMS form 10123, which had information on whether R4 wanted to appeal the decision, when the resident's skilled services ended on 06/05/25.On 09/29/25 at 02:02 PM, Administrative Staff A stated that Administrative Staff B was responsible for ABN.On 09/29/25 at 02:20 PM, Administrative Staff B verified the lack of documentation regarding a CMS form 10123 and stated she could not find the form.The facility's Medicare Advance Beneficiary and Medicare Non-Coverage Notice Policy, revised September 2024, documented if the resident's Medicare covered Part A stay or when all of Part B therapies are ending, a Notice of Medicare Non-Coverage (CMS form 10123) would be issued to the resident at least two calendar days before Medicare covered services end for the second to the last day of service if care is not provided daily.

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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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. (continued on next page)

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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 0628 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 had a census of 27 residents. The sample included 12 residents, with three reviewed for hospitalization. Based on observation, record review, and interview, the facility failed to notify the Office of the Long-Term Care Ombudsman (LTCO- a public official who works to resolve resident issues in nursing facilities) for two residents. Resident (R) 4 and R5 and failed to provide R5 with written information regarding the facility's bed hold policy when they were transferred to the hospital.Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of orthostatic hypotension (blood pressure dropping with change of position), vertigo (sensation of spinning and dizziness), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and left artificial hip joint (a man-made implant that replaces damaged or diseased portions of the natural hip to restore function and relieve pain).R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had intact cognition. R4 required partial staff assistance for oral hygiene, upper body dressing, and transfers. R4 was independent with eating, personal hygiene, and mobility.The Significant Change MDS, dated 07/29/25, documented R4 had intact cognition. R4 required partial staff assistance for showers, dressing, personal hygiene, transfers, ambulation, and mobility.R4's Care Plan dated 08/12/25, initiated on 04/25/23, documented R4 was at risk for injury due to balance problems and she had a grabber to assist with reaching items. The update, dated 12/16/24, documented R4 was on a walking program.The Nurse's Notes dated 04/19/24 at 12:25 PM documented R4 was admitted to the hospital with a left hip hemiarthroplasty (a surgical procedure that replaced the ball-shaped end of the thigh bone with a metal implant while leaving the hip socket intact).R4's clinical record lacked evidence that the facility notified the Ombudsman of the hospital transfer.R4's Nurse's Notes dated 04/24/25 at 08:15 PM documented R4 was readmitted back into the facility.On 09/30/25 at 08:30 AM, R4 laid in bed, with her eyes closed.On 09/30/25 at 02:20 PM, Social Services X stated the ombudsman was not notified of the transfer. Social Service X stated she usually notified the ombudsman at the end of the month for transfers out of the facility.On 09/30/25 at 03:30 PM, Administrative Nurse D stated the Ombudsman was notified at the end of the month when a resident was transferred from the facility.The facility's Transfer or Discharge Notices policy, dated 03/2025, documented that residents (or resident representatives) were notified of an impending transfer or discharge and the reasons for the move in writing and in a language and manner they understand. A copy of the notice was sent to the Office of the State Long-Term Care Ombudsman.- The Electronic Medical Record (EMR) for R5 documented diagnoses of schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), diabetes mellites (DM- when the body cannot use glucose, not enough insulin was made, or the body cannot respond to the insulin) type two, pain, amputation of left lower extremity (surgical removal of the left lower leg), and dementia (a progressive mental disorder characterized by failing memory and confusion). R5's Annual Minimum Data Set (MDS), dated [DATE], documented R5 had intact cognition. R5 was dependent upon staff for assistance with oral hygiene, dressing, showers, personal hygiene, transfers, and did not ambulate.The Quarterly MDS, dated 07/29/25, documented R5 had intact cognition. R5 was dependent upon staff for assistance with toileting hygiene, showers, personal hygiene, dressing, transfers, and did not ambulate.R5's Care Plan dated 08/06/25, initiated on 07/30/25, documented R5 had chronic pain and directed staff to offer position changes, heat or cool packs, and administer medications as ordered. The update, dated 04/23/25, documented R5 had limited physical mobility due to her left lower leg amputation and directed staff to use two staff and a full-body mechanical lift for transfers.The Nurse's Notes dated 04/14/25 at 03:56 PM documented R5 was scheduled for a left above the knee amputation on 04/17/25.The Nurse's Note dated 04/17/25 at 12:34 PM documented R5 was transported to the hospital.The clinical record lacked documentation the family or R5 received bed hold notification or that the Ombudsman was notified of the hospital transfer.On 09/29/25 at 09:15 AM, R5 sat in a Broda chair (a specialized, high-end positioning wheelchair or chair designed for individuals with mobility challenges who require long-term support), in her room, and looked out her window.On 09/30/25 at 02:20 PM, Social Services X stated a bed hold notification was not provided to the family or resident prior to transfer to the hospital. Social Service X further stated the ombudsman was not notified of the transfer.On 09/30/25 at 03:30 PM, Administrative Nurse D stated a bed hold notification should have been provided to the resident. Social Service X stated she usually notified the ombudsman at the end of the month for transfers out of the facility but must have missed it.The facility's

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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 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan for two residents, Resident (R) 14 for lymphedema (swelling caused by accumulation of lymph) and R6 for his diagnosis of posttraumatic stress disorder (PTSD- a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress).Findings included:- The Electronic Medical Record (EMR) for R14 documented diagnoses of lymphedema, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, or irrational fear), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R14's Quarterly Minimum Data Set (MDS), dated [DATE], documented R14 had intact cognition. R14 was independent with eating, oral hygiene, personal hygiene, mobility, and transfers. The MDS further documented R14 had no skin issues. R14's Care Plan dated 09/02/25 lacked documentation of her diagnosis of Lymphedema and directions for staff related to her compression glove and wrap. The Physician's Order dated 06/09/23 documented R14 had a right upper extremity compression garment (elastic, tight-fitting garments that apply graduated pressure to the body to improve circulation, reduce swelling, and support tissues for various medical and athletic purposes). Staff were directed to put the glove on first, then the sleeve, then wrap with the ACE (an elasticized bandage, usually in a continuous strip to securely bind an injured wrist, knee, or other joint) wraps in the morning. The wrap would need to be adjusted throughout the day as it would become loose; it should be snug but not tight. The staff were further directed to leave it off at night if her arm was elevated. On 09/30/25 at 02:45 PM, R14 sat in her recliner, her right arm rested upon a pillow, and she did not have the glove or compression wrap on. R1 stated she had asked the staff not to put it on today because she did not like it, as it would get too tight and be uncomfortable. On 09/30/25 at 09:30 AM, Certified Nurse Aide (CNA) N stated, R14 refused her wraps and would tell the nurses she didn't want to wear them. On 09/30/25 at 03:00 PM, Licensed Nurse (LN) G stated R14 has never liked to wear the glove or the wrap. The staff have continued to tell the physician that she refused it, but they are to continue to offer it to her. LN G further stated, multiple appointments had been made to get a better-fitting compression garment. R14 would agree to the appointment, but on the day they are to go, she would change her mind. On 09/30/25 at 03:20 PM, Administrative Nurse D stated a care plan for the lymphedema with direction to the staff as to when she had it on or if she refused should have been developed and implemented. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Care Plans, Comprehensive Person-Centered policy, dated March 2022, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and their family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care plan reflected currently recognized standards of practice for problem areas and conditions. - R6's Electronic Medical Record (EMR) documented diagnoses of posttraumatic stress disorder, major depressive disorder (MDD- major mood disorder that causes persistent feelings of sadness), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R6 had no behaviors during the observation period. The MDS documented R6 had received antidepressant medication (a class of medications used to treat mood disorders) during the observation period. R6's Psychotropic Drug Use Care Area Assessment (CAA) dated 08/07/25 triggered due to the use of antidepressant medication to manage depression diagnosis. The CAA documented the resident takes Cymbalta (antidepressant medication) for depression, lacked any other identifying triggers, risk factors, and what to monitor with the medication use. R6's Care Plan dated 05/22/25 documented R6 has a depression diagnosis due to a stroke, and staff would monitor R6 for monitor the resident for depression, hopelessness, sadness, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness. R6's Care Plan lacked documentation of trauma-based triggers and individualized interventions for R6's diagnosis of PTSD. The 05/08/25 psychiatric evaluation from a Behavioral Health service visit documented the resident had intrusive thoughts with flashbacks related to his military experience in Vietnam. The notes documented R6 had difficulty sleeping with anxiety, and the anxiety included excessive worrying. The behavioral notes documented the resident had MDD, PTSD, with logical thoughts, and the physician prescribed Cymbalta 30 milligrams (mg), oral twice a day for major depressive disorder, and the physician hoped the medication would help with his PTSD, insomnia, and pain. On 09/29/25 at 09:20 AM, R6 was observed sitting at the dining room table eating breakfast independently and dressed in street clothes. Continued observation revealed the administrator's dog was on a leash and tied to the residents dining room chair. On 09/30/25 at 08:30 AM, Administrative Nurse E, the MDS coordinator, stated R6 had a diagnosis of PTSD after review of the behavioral health notes and verified R6's care plan lacked the information regarding the PTSD and lacked triggers with the PTSD diagnosis. Administrative Nurse E stated the care plan should be individualized and they would add the information needed for the resident diagnosis, behaviors and triggers and what staff would do to help R6 with the triggers. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Trauma Informed Care and Culturally Competent Care policy, dated August 2022, documented the policy would guide staff in providing cares that is culturally competent and trauma-informed in accordance with professional standards of practice. The policy documented all staff were provided in-service training about trauma and trauma informed care in the context of the health care setting. Nursing staff are trained on trauma screening and assessment tools. All staff are guided in evidence-based organizational and interpersonal strategies that support trauma informed culturally competent care. All staff receive orientation and in-services training regarding cultural competency as an aspect of resident centered care. The policy documented traumatic events which may affect resident during their lifetime include physical, sexual and emotional abuse, neglect, interpersonal or community violence, serious injury or illness, bullying, forced displacement, racism, war, generational or historical trauma. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. The facility would evaluate the need for trauma-informed practices as part of the facility assessment and select screening and assessment tools in collaboration with the QAPI committee. The facility would perform universal screening of residents, which include a brief, non-specific identification of possible exposure to traumatic events. The facility would develop individualized care plans that address post-traumatic trauma in collaboration with the resident and families as appropriate. Identify and decrease exposure to triggers that may re-traumatize the resident. Recognize the relationship between post-trauma and current health concerns. Develop individualized care plans that incorporate language needs, culture, cultural preferences, norms and values. The facility would recognize the need for peer support, volunteerism and service provision by individuals that have experienced trauma and/or addictions. The facility's Care Plans, Comprehensive Person-Centered policy, dated March 2022, documented a comprehensive, person-centered care plan that includes measurable objectives and timetables to meet the resident's physical, psychosocial, and functional needs was developed and implemented for each resident. The interdisciplinary team, in conjunction with the resident and their family or legal representative, develops and implements a comprehensive person-centered care plan for each resident. The care plan interventions are derived from a thorough analysis of the information gathered as part of the comprehensive assessment. The care plan reflected currently recognized standards of practice for problem areas and conditions.

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 27 residents, with one resident reviewed for elopement (when a resident leaves the premises or a specific safe area without authorization and/or necessary supervision). Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent an elopement for cognitively impaired Resident (R) 7, whom the facility identified the resident as at high risk for wandering. On 08/26/25 at approximately 07:41 PM, R7 exited the South delayed-egress door in her wheelchair, which alarmed, and no staff responded to the sounding alarm. R7 exited the facility unsupervised, mobilized to the driveway, and continued to independently propel herself in a wheelchair across the concrete driveway into the city street, traversing approximately 200 feet. At approximately 07:42 PM, License Nurse (LN) H exited the nurse's station and looked down the South Hall at the door with the sounding alarm, then re-entered the nurse's station. At approximately 07:43:53 PM (one minute and 35 seconds later) LN H exited the nurse's station again and began walking down the South Hall where she observed R7 in the street. LN H yelled for help, and Certified Nurse Aide (CNA) M responded immediately, reached the resident outside in the driveway/street area, and assisted R7 back into the building. The facility failed to ensure R7 received adequate supervision to prevent an elopement, which placed R7 in immediate jeopardy. Findings included:- R7's Electronic Medical Record (EMR) documented diagnoses of subarachnoid hemorrhage (bleeding in the space just outside the brain), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and insomnia (inability to sleep).The Significant Change Minimum Data Set (MDS) dated [DATE], documented R7 had short-term/long-term memory loss and severely impaired cognition. The MDS documented R7 had trouble concentrating, felt depressed, and rejected cares. The MDS did not document the resident wandered. The Activities of Daily Living Care Area assessment (CAA) dated 07/25/25 documented R7 had dementia and anxiety. The CAA documented R7 had balance problems while standing, walking, and decreased muscular coordination.The Behavior CAA dated 07/25/25 documented the resident had lethargy and refused to eat with increased confusion.R7's Care Plan dated 09/15/25 documented R7 was an elopement risk and wandered due to disorientation to the place. The care plan directed staff to provide structured activities, toileting, walking inside and outside, and reorientation strategies, including signs, pictures, and memory books. The care plan documented the facility would have signs posted on all facility doors to notify staff to be aware the resident was not following them out of the facility, and noted she had a Wander Guard on her wrist. The Wander Risk Assessment dated 07/21/25 documented a score of 11, indicating a high risk. The Facility Incident Report, dated 09/03/25, documented on 08/26/25 at approximately 07:41 PM, R7 exited the South delayed-egress door in her wheelchair, which alarmed. R7 was observed mobilizing in her wheelchair, and as she reached the South door, R7 placed her hand on the bar and pushed the door until it released. Once R7 opened the door, she crossed the threshold, exited to the driveway, and continued to independently propel herself in a wheelchair across the concrete driveway into the city street, approximately 200 feet. The video camera printed footage documented at approximately 07:42 PM. License Nurse (LN) H exited the nurse's station and looked down the South Hall toward the alarming door, then re-entered the nurse's station. At approximately 07:43 PM, LN H exited the nurse's station again and began walking down the South Hall at 07:44:26 PM (seven seconds later). When LN H arrived at the South Hallway door, she observed R7 in the street. LN H yelled for help. Certified Nurse Aide (CNA) M responded immediately, reached R7 outside in the driveway/street area, and assisted R7 back into the building. The report documented R7's relative arrived at the facility while the resident was observed outside unattended.The 08/26/25 at 08:50 PM Nurse's Note documented a witnessed elopement attempt. LN H observed R7 from the smoker's door, no bodily harm or skin issues, and the resident remained seated in a wheelchair while outside of the building, family present, director of nursing notified, staff notified, and interventions in place. The 08/27/25 at 04:41 AM, Nurse's Note documented R7 propelled herself up and down the halls in a wheelchair and asked staff What time will they be here? (Referring to her daughter). Multiple staff answered R7 letting her know that her daughter would be at the facility soon. On 08/28/25 at 03:41 PM, a Communication With The Physician Note documented on 08/26/25, R7's exit from the facility was initially documented as a witnessed exit. Upon investigation on 08/28/25, camera review confirmed the resident's exit was not witnessed, the resident experienced a true elopement

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with one reviewed for respiratory care. Based on observation, record review, and interview, the facility failed to provide necessary respiratory care and services for Resident (R) 14, when staff stored the uncovered nebulizer (turns liquid medication into a mist so that you can inhale it into your lungs) mask on top of the nebulizer machine, and failed to ensure R14's nasal cannula (NC - a thin hollow tube that assists in providing supplemental O2) was appropriately stored when not used.Findings included:- The Electronic Medical Record (EMR) for R14 documented diagnoses of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, or irrational fear), and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).R14's Quarterly Minimum Data Set (MDS), dated [DATE], documented R14 had intact cognition. R14 was independent with eating, oral hygiene, personal hygiene, mobility, and transfers. The MDS further documented R14 used supplemental oxygen daily.R14's Care Plan dated 09/02/25, initiated on 09/06/24, directed staff to monitor for signs and symptoms of respiratory distress and report it to the physician. The care plan further directed staff to provide the resident with oxygen via nasal cannula at two liters at night or at rest. The Physician's Order, dated 02/22/24, directed staff to administer ipratropium-albuterol solution (a sterile medicated inhalation solution), 0.5-2.5 milligrams (mg)/3 milliliters (ml), nebulizer treatment, four times per day for COPD.The Physician's Order, dated 02/22/24, directed staff to provide R14 with supplemental oxygen, via nasal cannula at two to four liters, as needed to keep oxygen saturation (percentage of oxygen in the blood), above 90% every one hour or COPD.The Physician's Order, dated 06/05/24, directed staff to provide R14 supplemental oxygen at two liters per nasal cannula, via oxygen concentrator at bedtime.The Physician's Order, dated 05/23/25, directed staff to change the oxygen tubing, cannula, and fabric storage bag every seven days, per facility protocol, at bedtime on Friday. The oxygen tubing must be labeled with the date.The Physician's Order, dated 08/15/25, directed staff to change out the nebulizer and tubing every Thursday. Date and label the tubing at bedtime every Tuesday.On 09/29/25 at 08:45 AM, R14's nebulizer mask was uncovered on top of the nebulizer machine. Further observation revealed R14 oxygen tubing and cannula was wound up and place between the oxygen concentrator handle and machine uncovered.On 09/30/25 at 07:45 AM, R14's oxygen tubing and cannula was wound up and place between the oxygen concentrator handle and machine uncovered.On 09/30/25 at 02:45 PM, R14's nebulizer masked was uncovered on top of the nebulizer machine. Further observation revealed R14 oxygen tubing and cannula was wound up and place between the oxygen concentrator handle and machine uncovered.On 09/30/25 at 02:45 PM, R14 stated the oxygen tubing and her nebulizer masked should be in the fabric bags that are on the machines. R14 stated usually staff put them in their separate bags.On 09/30/25 at 03:00 PM, Licensed Nurse (LN) G stated the residents who have nebulizer treatments and oxygen therapy have fabric bags that all the tubing's should be placed in when not in use.On 09/30/25 at 03:20 PM, Administrative Nurse D stated the oxygen tubing and nebulizer tubing should always be in the bags when not in use.The facility's Departmental (Respiratory therapy)-Prevention of Infection policy, dated November 2011, directed staff to keep the oxygen cannula and tubing used as needed in a plastic bag when not in use. The policy further directed staff to store the nebulizer in the plastic bag, marked with the date and resident's name, in between use.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. (continued on next page)

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Frankfort Community Care Home	510 N Walnut Street Frankfort, KS 66427

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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 0699 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 identified a census of 27 residents. The sample included 12 residents, with three residents reviewed for trauma-informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 6 posttraumatic stress disorder (PTSD - a mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization, and major depressive disorder (MDD- major mood disorder that causes persistent feelings of sadness). Findings included:- R6's Electronic Medical Record (EMR) documented diagnoses of posttraumatic stress disorder, major depressive disorder, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin).The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R6 had no behaviors during the observation period. The MDS documented R6 had received antidepressant (a class of medications used to treat mood disorders) medication during the observation period. R6's Psychotropic Drug Use Care Area Assessment (CAA) dated 08/07/25 triggered due to the use of antidepressant medication to manage depression diagnosis. The CAA documented the resident takes Cymbalta (antidepressant medication) for depression, lacked any other identifying triggers, risk factors, and what to monitor with the medication use.R6's Care Plan dated 05/22/25 documented R6 has a depression diagnosis due to a stroke, and staff would monitor R6 for depression, hopelessness, sadness, verbalizing negative statements, repetitive anxious or health-related complaints, and tearfulness.R6's Care Plan lacked documentation of trauma-based triggers and individualized interventions for R6's diagnosis of PTSD. On 05/08/25, the psychiatric evaluation for a Behavioral Health service visit documented the resident had intrusive thoughts with flashbacks related to his military experience in Vietnam. The notes documented R6 had difficulty sleeping with anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and the anxiety included excessive worrying. The behavioral notes documented the resident had MDD, PTSD, with logical thoughts, and the physician prescribed Cymbalta (antidepressant -class of medications used to treat mood disorders) 30 milligrams (mg), oral twice a day for major depressive disorder, and the physician hoped the medication would help with his PTSD, insomnia, and pain. On 09/29/25 at 09:20 AM, R6 was observed sitting at the dining room table, eating breakfast independently, and dressed in street clothes. Continued observation revealed the administrator's dog was on a leash and tied to the residents' dining room chair. On 09/30/25 at 08:30 AM, Administrative Nurse E, the MDS coordinator, stated R6 had a diagnosis of PTSD after review of the behavioral health notes and verified R6's care plan lacked the information regarding the PTSD and lacked triggers with the PTSD diagnosis. Administrative Nurse E stated the care plan should be individualized and they would add the information needed for the resident's diagnosis, behaviors, and triggers, and what staff would do to help R6 with the triggers.The facility's Trauma Informed Care and Culturally Competent Care policy, dated August 2022, documented the policy would guide staff in providing care that is culturally competent and trauma-informed in accordance with professional standards of practice. The policy documented all staff were provided in-service training about trauma and trauma-informed care in the context of the health care setting. Nursing staff are trained on trauma screening and assessment tools. All staff are guided in evidence-based organizational and interpersonal strategies that support trauma-informed, culturally competent care. All staff receive orientation and in-service training regarding cultural competency as an aspect of resident-centered care. The policy documented traumatic events which may affect resident during their lifetime include physical, sexual, and emotional abuse, neglect, interpersonal or community violence, serious injury or illness, bullying, forced displacement, racism, war, generational or historical trauma. For trauma survivors, the transition to living in an institutional setting (and the associated loss of independence) can trigger profound re-traumatization. The facility would evaluate the need for trauma-informed practices as part of the facility assessment and select screening and assessment tools in collaboration with the QAPI committee. The facility would perform universal screening of residents, which includes a brief, non-specific identification of possible exposure to traumatic events. The facility would develop individualized care plans that address post-traumatic trauma in collaboration with the resident and families as appropriate. Identify and decrease exposure to triggers that

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident's drug regimen must be free from unnecessary drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with six reviewed for unnecessary medications. Based on observation, record review, and interview, the facility failed to hold blood pressure medication per the physician-ordered parameters for Resident (R) 4.Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of orthostatic hypotension (blood pressure dropping with change of position), vertigo (sensation of spinning and dizziness), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and nonrheumatic aortic valve stenosis (heart valve failure).R4's Quarterly Minimum Data Set (MDS), dated [DATE], documented R4 had intact cognition. R4 required partial staff assistance for oral hygiene, upper body dressing, and transfers. R4 was independent with eating, personal hygiene, and mobility. The MDS further documented R4 received antidepressant (a class of medications used to treat mood disorders), opioid (a class of controlled drugs used to treat pain), and hypoglycemic (a medication used to lower blood glucose levels) medications.The Significant Change MDS, dated 07/29/25, documented R4 had intact cognition. R4 required partial staff assistance for showers, dressing, personal hygiene, transfers, ambulation, and mobility. The MDS further documented R4 received antidepressant, opioid, and hypoglycemic medication.R4's Care Plan dated 08/12/25, initiated on 04/24/25, documented R4 received Black Box Warning Medication (BBW- the highest safety-related warning that medications can have assigned by the Food and Drug Administration) and was at risk for adverse reactions from her medications. The care plan directed staff to monitor for possible signs and symptoms of side effects and have her medications reviewed monthly by the Pharmacist Consultant. The update, dated 12/30/24, directed staff to administer medications as ordered and monitor and document for side effects and effectiveness.The Physician's Order, dated 04/11/24, directed staff to administer midodrine (hypotension medication) 0.5 milligrams (mg), by mouth, twice a day for orthostatic hypotension. The order directed to hold if her blood pressure was greater than 140/85 millimeters of mercury (mmHg).R4's Medication Administration Record (MAR), dated July 2025, documented the following days R4 received the midodrine when her blood pressure was over the ordered parameters:AM Dose07/18/25 - 149/93 mmHg07/22/25 - 173/88 mmHg07/24/25 - 142/91 mmHgPM Dose07/22/25 - 184/88 mmHg07/27/25 - 145/87 mmHgR4's MAR, dated August 2025, documented the following days R4 received the midodrine when her blood pressure was over the ordered parameters:AM Dose08/05/25 - 180/90 mmHg08/07/25 - 167/94 mmHgPM Dose08/12/25 - 140/91 mmHg08/17/25 - 147/86 mmHgR4's MAR, dated September 2025, documented the following days R4 received the midodrine when her blood pressure was over the ordered parameters:AM Dose09/20/25 - 154/88 mmHgOn 09/30/25 at 08:30 AM, R4 laid in bed, with her eyes closed. On 09/30/25 at 03:10 PM, Licensed Nurse (LN) G verified the blood pressures were out of physician-ordered parameters and were not held as ordered.On 09/30/25 at 03:30 PM, Administrative Nurse D stated staff should administer medication as ordered and follow the physician-ordered blood pressure parameters.The facility's Administering Medications policy, dated April 2019, directed staff to administer medications in a safe and timely manner, and as prescribed. Medications are administered in accordance with prescriber orders, including any required time frames. The following information is checked/verified for each resident before administering medications, vital signs, if necessary.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to label Resident (R) 27's insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened for use and when expired. Findings included: - On [DATE] at 09:10 AM, observation of the facility medication treatment cart revealed R27's Lantus (long-acting insulin) flex pen was not labeled with an opened date or an expired date.On [DATE] at 08:15 AM, License Nurse G verified the nurses should label and date the insulin flex pens with the date opened.On [DATE] at 08:00 AM, Administrative Nurse D verified the nurse should label and date the insulin flex pens with the date opened. Medlineplus.gov directs open, unrefrigerated Lantus can be used within 28 days; after that time, they must be discarded.The facility's Medication Labeling and Storage policy, dated 2001, documented labeling of medications and biologicals dispensed by the pharmacy was consistent with applicable federal and state requirements and currently accepted pharmaceutical practices the medication labels include the and residents name, medication name, prescribed dose, strength, expiration date, when applicable.

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. The facility had a census of 27 residents. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 27 residents who reside in the facility and received meals from the facility kitchen.Findings included:- On 09/29/25 at 11:00 AM, observation of the noon meal consisted of honey pot roast, potatoes, cabbage, and pineapple cake. Dietary Staff (DS) BB was observed overseeing the preparation of the noon meal. DS BB would also assist staff with taking meal trays to the residents.On 09/29/25 at 08:45 AM, DS BB stated she had just started a couple of months ago, was not certified, or started taking the classes yet.On 09/30/25 at 03:20 PM, Administrative Nurse D verified DS BB was not certified.The facility's Dietitian policy, dated July 2025, documented that a qualified, competent, and skilled dietitian would help oversee the food and nutrition services in the facility. If a dietitian was not employed full-time (35 hours or more per week), a director of food and nutrition services would be designated. This individual would be a certified dietary manager. The Dietary Manager who is not yet certified may document in the clinical record only after receiving documented training from the facility's licensed dietician on appropriate documentation standards and regulatory requirements by the supervising dietician to ensure clinical accuracy and compliance with federal and state regulations.

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F 0804 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature. The facility had a census of 27 residents. Based on observation, record review, and interview, the facility kitchen staff failed to take the food temperatures before serving the noon meal.Findings included: - On 09/30/25 at 11:15 AM, Dietary Staff (DS) CC prepared the noon meal of pork chop with gravy, mashed potatoes, and broccoli. Observation revealed DS CC ground three porkchops in the robot coupe (a commercial food processor) and placed the plastic 3-quart bowl in the steam table. DS CC made a plate of the regular meal for three residents and served them. DS CC did not obtain the food temperatures. When asked if she was going to temp the food before she served anyone else, DS CC stated she had already obtained the food temperatures earlier but had not documented it. DS CC stated she would take the food temperatures again. DS CC was questioned regarding taking the food temperatures of the pureed meal and ground meat. Continued observation revealed DS CC took the temperature of the main meal and also the pureed meal, but not the ground pork chop. Continued observation revealed DS CC plated two residents' plates that received the ground pork chop and did not temp before serving it to the two residents. DS CC continued to plate the meal for the rest of the residents in the dining room. When asked why she had not taken the temperature of the ground meat before serving, DS CC stated, I forgot, but would take it now. DS CC obtained the temperature of the ground pork chop at 105 degrees Fahrenheit. DS CC stated there were no other residents who would receive the ground meat.On 09/30/25 at 11:30 AM, DS BB stated that DS CC should have obtained food temperatures before serving the meal to the residents and that she had been working with the dietary staff on this. DS CC further stated that staff are starting to do a lot better at food temperatures than they used to be.The facility's Food Preparation and Service undated policy documented that identification of potential hazards in the food preparation process and adhering to critical control points can reduce the risk of food contamination and thereby minimize the risk of foodborne illness. Food preparation staff adhere to proper hygiene and sanitary practices to prevent the spread of foodborne illness. When verifying food temperatures, staff use a thermometer which was both clean, sanitized, and calibrated to ensure accuracy. The danger zone for food temperatures is above 41 degrees Fahrenheit and below 135 degrees Fahrenheit. This temperature range promotes the rapid growth of pathogenic microorganisms that cause food borne illness. The longer foods remain in the anger zone the greater the risk for growth of harmful pathogens. Therefore, the temperatures must be maintained at or below 41 degrees or at or above 135 degrees.

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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 had a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store, prepare, distribute, and serve food by professional standards for food safety, and failed to consistently document sink and bucket PPM (parts per million) sanitation on the facility's PPM log (a record keeping document used in food service to monitor the concentration of sanitizing solutions in sinks and other equipment to ensure food safety).Findings included:- On 09/29/25 at 08:15 AM, during the initial kitchen tour, the daily temperature logs for the seven freezers and three refrigerator logs for September 2025 lacked documentation of daily temperatures.Freezer 1 in the AM: 3 out of 30 opportunitiesFreezer 1 in the PM: 8 out of 30 opportunitiesFreezer 2 in the AM: 2 out of 30 opportunitiesFreezer 2 in the PM: 9 out of 30 opportunitiesFreezer 3 in the AM: 2 out of 30 opportunitiesFreezer 3 in the PM: 10 out of 30 opportunitiesFreezer 4 in the AM: 2 out of 30 opportunitiesFreezer 4 in the PM: 10 out of 28 opportunitiesFreezer 5 in the AM: 2 out of 28 opportunitiesFreezer 5 in the PM: 12 out of 28 opportunitiesFreezer 6 in the AM: 2 out of 28 opportunitiesFreezer 6 in the PM: 10 out of 28 opportunitiesFreezer 7 in the AM: 3 out of 28 opportunitiesFreezer 7 in the PM: 9 out of 28 opportunitiesRefrigerator 1 in the AM: 2 out of 28 opportunitiesRefrigerator 1 in the PM: 9 out of 28 opportunitiesRefrigerator 2 in the AM: 3 out of 28 opportunitiesRefrigerator 2 in the PM: 9 out of 28 opportunitiesRefrigerator 3 in the AM: 3 out of 28 opportunitiesRefrigerator 3 in the PM: 10 out of 28 opportunitiesOn 09/29/25 at 08:15 AM, during the initial kitchen tour, review of the daily sink and bucket sanitizer PPM log lacked documentation of the chemical PPM for the sanitizing solution was not documented the following times:Sink in the AM:13 out of 28 opportunitiesSink in the PM:21 out of 28 opportunitiesBucket in the AM:14 out of 28 opportunitiesBucket in the PM:21 out of 28 opportunitiesOn 09/29/25 at 08:15 AM, during the initial kitchen tour, review of the daily food temperature log lacked documentation meal temperatures were obtained on the following days:08/01/25 - dinner08/02/25 - dinner08/11/25 - lunch08/12/25 - breakfast08/15/25 - lunch08/20/25 - dinner08/21/25 - breakfast and lunch08/22/25 - breakfast, lunch, and dinner08/23/25 - breakfast, lunch, and dinner08/24/25 - dinner08/25/25 - dinner08/26/25 - dinner08/27/25 - dinner08/28/25 - dinner08/29/25 - breakfast, lunch, dinner08/30/25 - dinner08/31/25 - dinner09/01/25 - breakfast, lunch, and dinner09/02/25 - breakfast and lunch09/04/25 - lunch and dinner09/08/25 - lunch09/11/25 - dinner09/12/25 - dinner09/13/25 - lunch and dinner09/14/25 - breakfast, lunch, and dinner09/15/25 - dinner09/16/25 - dinner09/17/25 - dinner09/18/25 - dinner09/20/25 - dinner09/21/25 - breakfast, lunch, and dinner09/22/25 - dinner09/23/25 - diner09/24/25 - dinner09/26/25 - dinner09/28/25 - dinnerOn 09/29/25 at 08:30 AM, Dietary Staff (DS) BB stated she had struggled with staff not taking daily temperatures of the freezers and meals, but was working on it with the staff.The facility's Refrigerators and Freezers policy, dated November 2022, documented that the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and would observe food expiration guidelines. The policy further documented monthly tracking sheets for all refrigerators and freezers were posted to record temperatures. Food service supervisors or designated employees check and record refrigerator and freezer temperatures daily upon first opening and at closing in the evening.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. (continued on next page)

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F 0849 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 had a census of 27 residents. The sample included 12 residents, with one reviewed for hospice (a type of health care that focused on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure coordinated care and services provided by the facility with the care and services provided by hospice for Resident (R) 1. Findings included: - R1's Electronic Medical Record (EMR) revealed diagnoses of senile degeneration of the brain (the gradual decline in cognitive function and brain structure that occurs with aging), dementia (a progressive mental disorder characterized by failing memory and confusion), atrial fibrillation (an irregular, often rapid heart rate that commonly causes poor blood flow), and basal cell carcinoma (skin cancer that forms in the basal cells of your skin) of the skin.R1's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R1 had severely impaired cognition. The MDS recorded she required staff assistance with transfers and activities of daily living (ADL). The MDS documented the resident received hospice services. R1's Activities of Daily Living (ADL) Care Plan, dated 08/19/25, recorded R1 required staff supervision with most ADL care. R1's plan of care documented the resident had bilateral lower extremity contractures, and staff would monitor for skin breakdown and increased immobility.R1's updated Care Plan, dated 9/10/25, documented R1 had a terminal prognosis due to senile degeneration of the brain, and the family had elected hospice to provide cares at the facility. The care plan lacked instruction on the services provided by hospice, including the frequency and type of support visits, supplies and medical equipment provided by hospice, medications covered by hospice, and the hospice contact information.Review of R1's clinical record revealed the resident was admitted to hospice care on 08/28/25 with a diagnosis of senile degeneration of the brain.On 09/29/25 at 12:10 PM, R1 was dressed in street clothes, sitting in a wheelchair at the dining room table, eating lunch. On 09/29/25 at 08:25 AM, Administrative Nurse D verified the facility lacked specific information on the facility care plan that coordinated with the hospice plan of care. The facility's Hospice Program policy, dated July 2017, documented hospice services were available to residents at the end of life. The facility has an agreement in place with at least one Medicare-certified hospice to ensure that residents who wish to participate in a hospice program may do so. A resident who has been diagnosed as terminally ill, the director of nursing services would contact the hospice agency and request that a visit/interview with the resident and family be conducted to determine the resident's wishes relative to participating in the hospice program. It was the responsibility of the hospice to manage the resident's care as it relates to the terminal illness and related conditions, including the following:a. Determining the appropriate hospice plan of careb. Changing the level of services provided when it is deemed necessaryc. Providing medical direction, nursing, and clinical management of the terminal illness. d. Providing spiritual, bereavement, and/or psychosocial counseling and social services as needede. Providing medical supplies, durable medical equipment, and medications necessary for the palliation of pain and symptoms. The policy documented it is the responsibility of the facility to meet the resident's personal care and nursing needs in coordination with the hospice representative and ensure that the level of care provided is appropriately based on the individual resident's needs. Communicate with the hospice provider to ensure that the needs of the resident are addressed and met 224 hours per day. Hospice would coordinate care provided to the resident by the facility staff and the hospice staff. Collaborating with hospice representatives and coordinating facility staff participation in the hospice care planning process for the terminal illness, related conditions, and other conditions, to ensure quality care for the resident and family. Ensure the facility communicates with the hospice medical director, the resident's attending physician, and other practitioners participating in the provision of care to the resident as needed to coordinate the hospice care with the medical care provided by other physicians. The coordinating care plan would reflect the residents' goals and wishes, as stated in his or her advanced directives and during ongoing communication with the resident or representative, including palliative goals, objectives, palliative interventions, and medical treatment and diagnostic tests. The coordinated care plan will be revised and updated as necessary to reflect the resident's current status.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility had a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure their Medical Director attended the Quality Assessment and Assurance (QAA) Committee quarterly meetings. Findings included:- On 09/30/25 at 02:30 PM, the facility provided QAA committee attendance rosters for 03/01/24, 10/23/24 (6 months no meeting), 01/22/25, and 04/16/25 until the present (6 months no meeting), and in which the medical director had been present for the three meetings but had not been present for the 01/22/25. The facility only provided documentation for three quarters of the four required for the year 2024 to 2025.On 09/30/24 at 04:30 PM, Administrative Staff A verified the QAA meetings should be held quarterly and were to include the medical director and verified the lack of quarterly meetings, and verified the medical director did not attend some of the meetings.The facility's Quality Assurance and Performance Improvement policy, dated August 2025, documented the quality assurance and performance improvement program was overseen and implemented by the QAPI committee, which reports its findings, actions, and results to the administrator and governing body. The Administrator, whether a member of the QAPI committee or not, is ultimately responsible for the QAPI program and for interpreting its results and findings to the governing body. The responsibility of the QAPI committee are to collect and analyze performance indicator data and other information; identify, evaluate, monitor, and improve facility systems and process that support the delivery of care and services; identify and help resolve negative outcomes and/or care quality problems identified during the QAPI process; utilize root cause analysis to help identify where known problems point to underlying systematic problems; help departments, consultants, and ancillary services implement systems to correct and actual issues in quality of care; establish benchmarks and goals to measure performance improvements; consider the current and trending sub-populations to address any health equity issues represented within the facility; coordinate the development, implementation, monitoring, and evaluation of performance improvement projects to achieve specific goals; and communicate all phases of the QAPI process to the administrator and governing body through meeting minutes, committee activities, and results of QAPI activities. The following individuals serve on the committee: Administrator, Director of Nursing, Medical Director, Infection Preventionist, Representatives from Pharmacy, Dietary Service, Activity Services, Environmental Services, Human Resources, and Medical Records/ The committee meets at least quarterly, or more often as necessary. Committee members are reminded of meeting day, time, and location via e-mail at least two business days prior to the meeting. Special meetings may be called by the Administrator as needed to present issues that need to be addressed before the next regularly scheduled meetings.

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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 - Many	Provide and implement an infection prevention and control program. The facility had a census of 27 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to provide enhanced barrier precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms which employ targeted gown and glove use during high contact care) for Resident (R) 2. Findings included:- On 09/30/25 at 08:20 AM, observation revealed R2 sat in a wheelchair in his room. Licensed Nurse (LN) G and Consultant GG entered R2's room and asked R2 if they could change the dressing on his right outer ankle. R2 replied, Sure. Observation revealed all items needed for dressing change were on a barrier on R2's bed. Consultant GG and LN G applied gloves, Consultant GG removed R2's sock and dressing on his outer ankle, to reveal a scant amount of green drainage on the dressing, measured the wound area, discarded the dressing in a trash can, then removed and discarded his gloves. LN G cleansed the wound area with normal saline on a gauze pad, removed and discarded gloves. Both applied new gloves. Consultant GG stated that since the wound had green drainage, instructed LN G to apply Therabond (wound care product made of silver-plated nylon fabric with a unique 3-D structure that creates a moist healing environment by managing exudate (a fluid that leaks out of body vessels and tissue) and cover with opsite (dressings are used to protect and cover various wounds). LN G removed and discarded gloves, left the room, and came back with a Therabond dressing. LN G applied gloves and placed the Therabond dressing on the wound area and covered it with an opsite dressing.On 09/30/25 at 12:55 PM, LN G verified R2 was not on EBP, and stated he probably should be.On 09/30/25 at 09:20 AM, Administrative Nurse D verified R2 was not on EBP, but should be.The facility's EBP Policy, revised 12/2024, documented EBP applied when:a. A resident is infected or colonized with a Centers for Disease Control and Prevention (CDC) -targeted MDRO but does not have a wound or indwelling medical device and does not have secretions or excretions that cannot be covered or contained.b. A resident is not known to be infected or colonized with multiple drug-resistant organisms has a wound or indwelling medical device, which includes central lines, urinary catheters, feeding tubes, and tracheostomies, and does not have secretions or excretions that are unable to be covered or contained, and c. Contact precautions do not otherwise apply. The policy documented gloves and a gown were applied prior to performing the high-contact resident care activity (as opposed to before entering the room). Examples of high contact resident care activities requiring the use of gown and gloves for EBP's included: dressing, bathing/showering, providing hygiene or grooming, changing briefs or assisting with toileting; providing bed mobility; changing linens; prolonged, high contact with items in the resident's room, with resid's equipment, or resident's clothing or skin and wound care.