| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
|---|---|---|---|
| | 175424 | A. Building<br>B. Wing | 06/24/2026 |

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| Lakepoint Augusta, LLC | 901 Lakepoint Drive<br>Augusta, KS 67010 |

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| F 0759<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Some | Ensure medication error rates are not 5 percent or greater.<br><br>Based on observation, record review, and interview, the facility failed to ensure a medication error rate below five percent. Twenty-six medications administrations were observed with 15 errors identified, resulting in a medication error rate of 57.69 %. Findings included:1. Review of the Electronic Health Record (EHR) for Resident (R) 6 revealed the following orders:Finasteride (medication used to treat male pattern hair loss or enlarged prostate) five milligrams (mg), give one tablet via gastrostomy tube (G-tube: tube surgically placed through an artificial opening into the stomach) one time a day.Fludrocortisone acetate (a synthetic corticosteroid) 0.1 mg, give one tablet via G-tube one time a day.Furosemide (a loop diuretic) 40 mg, give two tablets via G-tube in the morning.Gabapentin (medication used to treat nerve pain and to control certain types of seizures) 600 mg, give one tablet via G-tube three times a day.Metoprolol (medication used to treat high blood pressure) 25 mg, give via one tablet via G-tube in the morning.Midodrine (medication used to treat low blood pressure when standing) 10 mg, give one tablet via G-tube three times a day.24-hour (hr) Mirabegron (used to treat the symptoms of overactive bladder) 8 mg/milliliter (ml) extended-release suspension, give 3 ml via G-tube in the morning.Oxybutynin (medication used to treat urinary urgency, frequency, and incontinence) 5 mg, give one tablet via G-tube three times a day.Potassium Chloride (a medication to treat low blood potassium) 15ml/20 milliequivalent (MEQ), give 15 ml via G-tube two times a day.Simvastatin (a medication used to lower cholesterol) oral suspension 40 mg/5ml, give 5 ml via G-tube in the morning.ProSource oral liquid (nutritional supplement), give 30 ml via G-tube three times a day.Probiotic, give one tablet via G-tube one time a day.Clopidogrel (medication used to prevent blood clots) 75 mg, give one tablet via G-tube one time a day.Ferrous sulfate (oral iron supplement) 325 mg, give 1 tablet via G-tube one time a day.R6's EHR lacked orders for medications to be crushed and/or mixed and lacked an order for an oral tablet for simvastatin.Observed on 06/23/2026 at 11:00 AM, Licensed Nurse (LN) H crushed R6's oral tablet medications, which included an oral tablet for simvastatin and mixed them all in a cup with liquid medication. At 11:33 AM provided R6 his crushed and mixed medications via G-tube. LN H performed hand hygiene and wore gloves only. On 06/23/2026 at 11:22 AM, LN H said that all oral medication tablets were crushed and mixed with his ProSource, potassium chloride and mirabegron oral suspensions. She then confirmed there was no current order to crush R6's medications or to combine them and confirmed there should have been an order to crush and combine the medications.2. On 06/22/2026 at 08:05 AM, Certified Medication Aide (CMA) R administered R34's aerosol 160-4.5 micrograms (mcg)/activated clotting time (ACT) (Budesonide-Formoterol Fumarate Dihydrate) one puff inhaled orally two times a day for chronic obstructive pulmonary disease. CMA R did not offer or encourage R34 to rinse her mouth after administration as ordered.On 06/23/2026 at 12:35 PM, Administrative Nurse D said that prior to crushing and/or mixing any medications an order should be obtained from the physician, and the pharmacist should be consulted to ensure medications could safely be mixed.The facility's policy Administering Medications, date April 2019, documented that medications were to be administered in a safe and timely manner, and as prescribed. The policy washer documented that the individual administering the medication was to check the label and verify that it was the right resident, right medication, right dosage, right time, and right method (rout) of administration before giving the medication. |

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 0550<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights.<br><br>Based on interviews, observation, and record review, the facility failed to ensure Resident (R) 22's was treated with respect and dignity while waiting to be assisted with meals.Findings included:-<br>R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), need for assistance with personal care, senile degeneration of brain, 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 05/15/2026, documented a Brief Interview of Mental Status (BIMS) score of three which indicated severely impaired cognition. The MDS documented R22 was dependent on staff assistance with all activities of daily living.R22's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 05/28/2026, documented she was at risk for a self-care deficit related to her dementia (a progressive mental disorder characterized by failing memory and confusion).R22's Care Plan documented the following interventions: 02/20/2026 - She needed assistance with all decision making. She enjoyed talking with roommate and staff. She had little activity involvement related to her immobility.On 06/22/2026 at 08:18 AM, R22 sat reclined in her Broda chair (specialized wheelchair with the ability to tilt and recline) at the end of the dining room table. She faced away from her table mate. A cup of fluid sat on the table out of reach.On 06/23/2026 at 07:41 AM, R22 sat reclined in her Broda chair at the end of the dining room table. A glass of fluid sat on the table out of reach. She sat with her back to her table mate. At 08:17 AM, her table mate exited the dining room and R22 sat alone at the dining room table. At 08:23 AM, Certified Nurse Aide (CNA) P sat with R22 and assisted her with breakfast.On 06/23/2026 at 11:15 AM, R22 sat at the dining room table in her Broda chair with her back to her table mate. At 11:42 AM, an unidentified staff member placed a cup of fluid on the table out of R22's reach and the staff member sat down alone at another dining room table. At 12:04 PM, CNA P sat down with R22 and assisted her with lunch. On 06/24/2026 at 09:26 AM, CNA Q stated a resident should not have to sit in the dining room waiting for assistance with meals more than five to 10 minutes.On 06/24/2026 at 09:47 AM, Licensed Nurse (LN) G stated a resident should never sit in the dining room more than 20 to 30 minutes before staff assisted them with their meals.On 06/24/2026 at 12:35 PM, Administrative Nurse D stated R22 enjoyed sitting in the dining room. She stated R22 could ask to be moved if she wanted to sit in a different position.The facility's Dignity policy, last revised 02/2021, documented each resident would be cared for in a manner that promotes and enhances his or her sense of well-being, level of satisfaction with life, and feelings of self-worth and self-esteem. |

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| F 0554<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Allow residents to self-administer drugs if determined clinically appropriate.<br><br>Based on observation, record review, and interviews, the facility failed to ensure safe and appropriate self-administration of medication for Resident (R) 23, R37, and R45, which placed these residents at risk for unnecessary medication side effects and self-administration errors.Findings included:1. R23's Electronic Medical Record (EMR) from the admission Minimum Data Set (MDS), dated 05/28/2026, documented a Brief Interview of Mental Status (BIMS) score of 15 which indicated intact cognition.Review of R23's EMR physician orders under the Orders tab lacked an order for self-administration of medications.Review of R23's EMR under the Assessment tab lacked an assessment for safe self-medication administration.On 06/22/2026 at 08:11 AM, R23 laid on her bed with the bedside table next to the bed, a paper medication cup with pills sat on the bedside table. 2. R37's EMR from the Quarterly MDS, dated 04/17/2026, documented a BIMS score of 12, which indicated moderately impaired cognition. Review of R37's EMR physician orders under the Orders tab lacked an order for self-administration of medications.Review of R37's EMR under the Assessment tab lacked an assessment for safe self-medication administration.On 06/22/2026 at 08:54 AM, R37 laid on his bed with the bedside table next to his bed, a paper medication cup with a pill sat on the bedside table.3. R45's EMR from the Significant Change MDS, dated 05/28/2026, documented a BIMS score of 15.Review of R45's EMR physician orders under the Orders tab lacked an order for self-administration of medications.Review of R45's EMR under the Assessment tab lacked an assessment for safe self-medication administration.On 06/22/2026 at 08:54 AM, R45 laid on his bed with the head of his elevated bedside table next to his bed. A paper medication cup with pills sat on the bedside table.On 06/24/2026 at 09:47 AM, Licensed Nurse (LN) G stated the residents can administer their own medications. LN G stated they are evaluated and determined to be safe by their BIMS score and then the physician would give an order for the residents to keep their medications in their room.On 06/24/2026 at 12:35 PM, Administrative Nurse D stated the residents are assessed for self-administration of their medications to determine if they are safe. She stated that assessment was documented in the resident's EMR under the Assessment tab. Administrative Nurse D stated then the resident's physician would give an order to self-administer their medication if they decide that was safe to do so. The facility's Self-Administration of Medications policy, last revised, 02/2021 documented residents have the right to self-administer medications if the interdisciplinary team has determined that it is clinically appropriate and safe for the resident to do so. |

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| F 0558<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Reasonably accommodate the needs and preferences of each resident.<br><br>Based on observation, record review, and interview, the facility failed to ensure Resident (R)13's call light was within his reach to enable him to call for staff assistance.Findings included:- R13's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of pain, history of falls, overactive bladder, and need for assistance personal care.The Quarterly Minimum Data Set (MDS), dated 05/15/2025, documented a Brief Interview of Mental Status (BIMS) score of seven which indicated severely impaired cognition. The MDS documented R13 had limited range of motion (ROM- the full movement potential of a joint, usually its range of flexion and extension) bilaterally lower extremities. The MDS documented R13 was dependent on staff assistance for toileting, bathing, and transfers.R13's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA), dated 12/01/2025, documented she required assistance with activities of daily living.R13's Care Plan documented the following interventions: 09/23/2025 - Staff would ensure her call light was within reach and would encourage her to use it for assistance as needed.On 06/22/2026 at 09:51 AM, R13 sat in her high back wheelchair in her room as she watched TV. R13's call light was pinned to the wall between her TV and dresser, out of her reach.On 06/09/2026 at 09:26 AM, Certified Nurse Aide (CNA)Q stated call lights should be placed on the person or clipped to the bed within reach.On 06/10/2026 at 09:47 AM, Licensed Nurse (LN) G stated call lights should always be within the resident's reach when in the room.On 06/03/2026 at 12:35 PM, Administrative Nurse D stated call lights should be within the resident's reach, if the resident was in their room. The facility's Accommodation of Needs policy, last revised 03/2021, documented the facility's environment and staff behaviors are directed toward assisting the resident in maintaining and/or achieving safe independent functioning, dignity, and well-being. |

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| F 0578<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive.<br><br>Based on observation, interview, and record review, the facility failed to verify Resident (R) 7's advanced directive (a legal document in which a person specified what actions should be taken for their health, which may or may not include a do not resuscitate [DNR-decision whether, or not, to withhold medical intervention in the event the resident's heart stops] order) was properly documented on his charts and care plan. Findings included: - Review of the Electronic Health Record (EHR) for R7 included diagnoses of transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain), chronic pain due to trauma, quadriplegia (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), major depressive disorder, and anxiety disorder.R7's Annual Minimum Data Set (MDS), dated 05/21/2026, documented a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition.R7's Care Plan, dated 05/23/2025, documented that R7 was a full code.R7's EHR home screen documented his code status (full code or DNR) as DNR.R7's EHR documented a Physician Order for DNR, dated 05/22/2026.R7's EHR, under the admission section, had a signed DNR, dated 05/14/2026, with an uploaded date of 06/23/2026 by Administrative Nurse D.Review of R7's hard chart, kept behind the nurse's station, contained a blue sheet which read full code.Observation on 06/23/2026 at 10:00 AM of R7's hard chart revealed a blue dot on the spine of the chart.On 06/23/2026 at 02:22 PM, Licensed Nurse (LN) I said the blue dot on the resident's hard chart notified staff that they were a full code and there was a DNR or blue sheet in the front of the chart, the code status was also in the EHR, and the resident care pan listed the code status. She verified R7's EHR listed him as DNR with an order and confirmed there was no DNR paperwork in the EHR. LN I said medical records performed the chart audits to make sure they were accurate and confirmed R7's Care Plan documented him as full code.On 06/23/2026 at 02:37 PM, R7 said that he wished to be a DNR. He reported that he had signed a DNR. On 06/24/2026 at 12:35 PM, Administrative Nurse D said that a resident's code status should be accurately uploaded in the EHR and the paper chart was to reflect the EHR. She also said it was a team effort to ensure the charts and EHR were accurate and should be corrected and updated regularly.The facility policy Advance Directives, dated September 2022, documented that if the resident or resident's representative had executed one or more advance directives, or executed one upon admission, copies of those documents were to be obtained and maintained in the same section of the resident's medical record and be readily retrievable by any facility staff. The policy also documented that the plan of care for each resident was consistent with his or her documented treatment preferences and/or advance directive. |

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| F 0583<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Keep residents' personal and medical records private and confidential.<br><br>Based on observation, record review, and interview, the facility failed to keep Resident (R) 23's protected health information (PHI) private on a medication cart parked in the main dining room.Findings included:- On 06/22/2026 at 07:45 AM, during initial tour a medication cart parked outside the dining room in the hallway with a laptop computer sitting on the top, the computer screen was unlocked and open, and R23's PHI was on the screen, visible to all who passed by the medication cart. The information visualized included R23's medications, date of birth , allergy information, and code status.On 06/22/2026 at 07:48 AM, Certified Medication Aide (CMA) R stated the computer screen should have been locked.On 06/24/2026 at 09:47 AM, Licensed Nurse (LN) G stated the medication should be locked, no personal information visible, and no medication left on the cart when staff walked away from the cart.On 06/24/2026 at 12:35 PM, Administrative Nurse D stated the medication cart should be clean, locked, and no personal health information left on the computer for others to see.The Facility's Confidentiality of Information and Personal Privacy policy, last revised 10/2017, documented the facility would protect and safeguard resident confidentiality and personal privacy. |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Protect each resident from the wrongful use of the resident's belongings or money.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 69 remained free from exploitation when facility staff reported that an employee coerced R69 into providing her $80. Findings included:- R69's Electronic Medical Record (EMR) documented diagnoses of major depressive disorder, pain, and insomnia.R69's Quarterly Minimum Data Set (MDS), dated 04/01/2026, documented a Brief Interview for Mental Status (BIMS) score of 12 which indicated moderate cognitive impairment. The assessment documented that R69 had little interest or pleasure in doing things and felt down and depressed.R69's Care Plan, with a revision date of 01/03/2025, documented that she had impaired cognitive function/dementia or impaired thought processes related to dementia. Interventions, dated 01/03/2025, instructed staff to cue, reorient, and supervise R69 as needed. Staff were also instructed to discuss concerns about confusion, disease process, and nursing home placement with R69, her family and caregivers.R69's Care Plan, with a revision of 04/16/2026, documented that she had depression. An intervention, with a date of 04/16/2026, instructed staff to monitor, document, and report as needed any signs or symptoms of depression, including hopelessness, anxiety, sadness, insomnia, anorexia, verbalizing any negative statements, repetitive or health-related complaints, or tearfulness.Certified Medication Aide (CMA) S's Notarized Witness Statement, dated 05/15/2026, documented she was giving R69's roommate medication and heard a housekeeper ask R69 if she could borrow $65.00 from her and R69 eventually said yes. She said that she heard R69 tell the housekeeper where her wallet was and after she removed that money from the wallet the housekeeper thanked R69 and promised to pay her back. The housekeeper then went around the privacy curtain and was startled to see CMA S in the room. CMA S documented that she immediately went and reported the incident to her supervisor.R69's Notarized Witness Statement, dated 05/15/2026, documented that on the morning of 05/15/2026 Housekeeping U went to R69s room and asked her for $10.00 for a pair of earrings R69 had bought from her. R69 told her she only had $20 bills and asked Housekeeping U if she had change, and she said no. Housekeeping U then asked R69 for an additional $65.00 for food and groceries. R69 documented that she and R69 then asked Housekeeping U to get R69's wallet and R69 pulled out $80.00 and gave it to Housekeeping U.The Facility Investigation, dated 05/15/2026, documented that on 05/15/2026 staff reported concerns regarding possible financial exploitation of R69 by Housekeeping U. It was reported that Housekeeping U had previously sold R69 handmade jewelry for approximately $10 and had approached R69 asking for the money and R69 had told Housekeeping U that she only had a $20 bill and requested change. Another staff member overheard the conversation and heard Housekeeping U request additional money from R69, and R69 then provided Housekeeping U with approximately $80. Based on the investigative findings, the facility terminated Housekeeping U on 05/15/2026, a police report was filed on 05/15/2026, and the facility reimbursed R69 the $80.00 on 05/15/2026.Observed on 06/023/2026 at 10:15 AM, R69 ambulated in the hall with her walker. She greeted other residents and staff pleasantly and with a smile.On 06/22/2026 at 09:02 AM, R69 reported that the previous month a housekeeper told her that she needed to buy groceries and kept telling R69 she had no money. R69 said she felt bad for the housekeeper, so she ended up giving her a total of $80.00. She then said that the facility immediately reimbursed her the $80.00.On 06/23/2026 at 08:28 AM, R45 said staff had never asked her for money or anything, she thought that administration might have talked to her about abuse, neglect, exploitation (ANE).On 06/23/2026 at 08:35 AM, R56 and R66 both said that no staff had ever asked either of them for money or anything and that every so often administration would talk to them about ANE what to do if anything related to ANE occurred. Both said that the most recent education occurred May 2026.On 06/23/2026 at 08:45 AM, Certified Nurse Aide (CNA) M said that she had just hired last month, and the facility provided online education for ANE through an e-learning platform and there had also been a policy handout that was reviewed. On 06/23/2026 at 09:05 AM, (continued on next page) |

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| F 0602<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Administrative Staff A said that ANE training occurred annually and anytime there was an instance or concern that arose. He said the last ANE education occurred a month ago and it was facility wide. Administrative Staff A said that last month a housekeeper exploited R69 for $80.00 and the facility immediately suspended the housekeeper and performed an investigation and reimbursed R69 the money on 05/15/2026. He said there were 34 residents interviewed by the social services designee (SSD) after the exploitation occurred, all residents had a BIMS of 12 or higher and the sample was throughout the building. He said that ANE education was facility wide and completed on 05/18/2026 and interviews were completed on 05/15/2026. Administrative Staff A also said that the employee was terminated, and a police report was filed. Review of the bank transaction from the facility to R69's account revealed that the facility reimbursed R69 the $80 on 05/15/2026, re-education was completed 05/18/2026, therefore PNC.The facility policy Lakepoint [NAME] Introduction to ANE documented that exploitation was illegal or improper use of an individual's resources for another person's profit or advantage. The policy documented that employees must understand their legal obligation to report any suspected abuse, neglect, or exploitation. |

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| F 0605<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on record review, interviews and observation, the facility failed to perform a gradual dose reduction (GDR) or provide a physician's rationale for not attempting the GDR for Resident (R) 44's psychotropic medications.Findings included:- R44's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of generalized anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and dementia (a progressive mental disorder characterized by failing memory and confusion).The Significant Change Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of 00 which indicated severely impaired cognition. The MDS documented R44 received an antipsychotic and antianxiety medication during the observation period.R44's Care Plan, dated 07/26/2024, documented R44 used psychotropic medications including Quetiapine (antipsychotic) and Haldol (antipsychotic) related to a mild neurocognitive disorder. Staff were to consult with the pharmacy and consider a dosage reduction when clinically appropriate at least quarterly.R44's EMR revealed the following orders:Duloxetine (antidepressant) 60 milligrams (mg) once daily, dated 07/27/2024.Quetiapine fumarate 50 mg twice daily, dated 02/20/2026.R44's EMR recorded a pharmacy consultant noted, dated 02/08/2026, which documented a recommendation was made and directed to see the medication review.The facility provided a Note To Attending Physician/Prescriber stamped as faxed on 02/10/2026 which documented R44 was receiving the following psychotropic medications that were due for review: haloperidol 1mg daily, quetiapine 37.5mg each morning and 25mg at bedtime and duloxetine 60 mg every morning. It listed a rationale that noted the Centers for Medicare and Medicaid (CMS) guidelines required psychotropic medications to be evaluated for dose reduction/discontinuation twice in the first year (at minimum), then at prescriber's discretion thereafter. The note listed several recommendations for GDR and asked for documented rationale. The physician did not mark any of the options listed but documented no change under the physician/provider response section. The response lacked a rationale why no GDR would be attempted.Observation on 06/22/2026 at 10:46 AM revealed that R44 laid in bed and appeared to be sleeping.Observation on 06/23/2026 at 08:39 AM revealed staff changed R44 and used a draw sheet to reposition him with no combative behavior or resistance from R44 observed.Observation on 06/23/2026 at 09:33 AM revealed R44 was in his bed and appeared to be sleeping.Observation on 06/23/2026 at 11:40 AM revealed the hospice nurse in the room assessing the resident who appeared to be sleeping.During an interview on 06/24/2026 at 09:21 AM, Administrative Nurse D stated that they had asked for a rationale for the consultant pharmacist recommendation related to the GDR but only had what was documented on the recommendation.The facility did not provide a policy related to psychotropic medications. |

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|---|---|---|---|
| | 175424 | A. Building<br>B. Wing | 06/24/2026 |

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| Lakepoint Augusta, LLC | 901 Lakepoint Drive<br>Augusta, KS 67010 |

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| F 0628<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies.<br><br>Based on observation, record review and interviews, the facility failed to ensure Resident (R)12, R76 and R37 and their representatives received a written notification of transfer that included a statement of the residents' rights, the transfer location, reason for the transfer and the state ombudsman information, as soon as practicable upon their transfer to the hospital. Additionally, the facility failed to notify the office of the Long-Term Care Ombudsman (LTCO) of the transfers.Findings included:1. R12's Electronic Medical Record (EMR) recorded a Discharge Minimum Data Set (MDS) dated 04/10/2026, which documented an unplanned discharge to an acute hospital with a return anticipated.R12's clinical record lacked evidence that a written notification of transfer was provided to R12 or their representative. Upon request, the facility was unable to provide evidence of the written notification.2. R37's Electronic Medical Record (EMR) recorded a Discharge Minimum Data Set (MDS) dated 04/27/2026, which documented an unplanned discharge to an acute hospital with a return anticipated.R37's clinical record lacked evidence that a written notification of transfer was provided to R37 or their representative. Upon request, the facility was unable to provide evidence of the written notification.3. R76's EMR recorded R76 was transferred to the hospital via Emergency Medical Services (EMS) on 04/30/2026 at 02:15 PM for evaluation of symptoms.R76's EMR lacked evidence that the facility provided written notification of the transfer to R76 and/or her representative.Review of the facility's Monthly Transfer Log to Hospital which was submitted to the LTCO monthly for the timeframe of 02/01/2026 to 05/31/2026 lacked documentation of R12's, R37's and R76's transfer to the hospital.On 06/24/2026 at 08:54 AM, Administrative Staff A stated the facility had not provided R12, R37 and R76 (or their legal representatives) with written notice of their transfer to the hospital. and confirmed the LTCO was not notified. Administrative Staff A stated the social service department was responsible for the notification.The facility did not provide a discharge policy. |

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| F 0761<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>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.<br><br>Based on observation, interview, and record review, the facility failed to ensure the staff had properly secured storage of resident medications. Findings included:- Observed on 06/22/2026 at 10:38 AM, Licensed Nurse (LN) G unlocked the treatment/nurse cart in the 100/200/300 hall and then left it unattended as she went down the 200 hall and into a resident's room. The cart contained seven boxes that contained nebulized breathing treatments, three containers of Vick's vapor rub, tubes of icy hot muscle rub, several tubes of calmoseptine ointment, and dressing change supplies. Also contained in the treatment cart were two insulin injector pens for Resident (R) 3, one insulin injector pen for R54, two insulin injector pens for R46, two insulin injector pens for R24, two insulin injector pens for R52, two insulin injector pens for R40, two insulin injector pens for R63, two insulin injector pens for R69, and two insulin injector pens for R70.On 06/22/2026 at 10:45 AM, LN G said that a medication or treatment cart should never have been left unlocked and unattended. On 06/24/2026 at 12:35 PM, Administrative Nurse D said that any time a nurse or medication aide walked from the medication cart area or treatment cart the cart should have been cleaned and locked and no resident information readily available for viewing by unauthorized persons.The facility policy Medication Labeling and Storage, dated February 2023, documented that compartments (including, but not limited to, drawers, cabinets, rooms, refrigerators, carts, and boxes) containing medications and biologicals would be locked when not in use, and trays or carts used to transport such items would not be left unattended when open or otherwise potentially available to others. |

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| F 0804<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Ensure food and drink is palatable, attractive, and at a safe and appetizing temperature.<br><br>Based on observation, interview, and record review, the facility failed to ensure staff served meals at safe and appetizing temperatures.Findings include: - On 06/23/2026 at 09:36 AM, Certified Nursing Aide (CNA) L delivered a breakfast meal to a room in the 100 hall. The temperature of the items was as follows:116 degrees Fahrenheit (F) for the hashbrowns.114 degrees F for the cheese omelet.115 degrees F for oatmeal.On 06/22/2026 at 08:15 AM, Resident (R) 70 stated the food arrives to his room cold.On 06/23/2026 at 09:40 AM CNA L said she was not sure how hot the food was supposed to register, but it likely should have been hotter.On 06/23/2026 at 10:55 AM, Dietary BB stated the standing warmer directly inside the door into the kitchen was used to hold the prepared meals for the residents that choose to eat in their rooms. Dietary BB stated the temperature of this warmer, referred to as the hot box, should be 145 degrees F. Dietary BB verified the temperature inside the warmer as 110 degrees F and stated the temperature could not be adjusted higher.The facility policy did not address palatable temperatures. |

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| F 0880<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide and implement an infection prevention and control program.<br><br>Based on interviews and observation, the facility staff failed to implement adequate infection control practices related to 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).Findings included:- During an observation on 06/23/2026 at 11:33 AM, observation revealed there was no signage or readily available personal protective equipment (PPE) to include gowns for Resident (R) 6 who had a gastronomy tube (G-tube: tube surgically placed through an artificial opening into the stomach). Further observation revealed that Licensed Nurse (LN) H donned gloves but no gown and provided R6 his medications via the G-tube. LN H verified that both a gown and gloves should have been worn for EBP.During an interview on 06/23/2026 at 08:45 AM, Certified Nurse Aide (CNA) M reported that EBP and PPE would be used by staff whenever a resident had an infection, CNA M said it was also used if the resident had a urinary catheter.During an interview on 06/24/2026 at 12:35 PM, Administrative Nurse D reported EBP and PPE are used for any indwelling device and any open wound being treated. The facility did not provide a policy for EBP or PPE practices. |

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| F 0732<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Post nurse staffing information every day.<br><br>The facility reported a census of 67 residents. Based on observation and interview, the facility failed to ensure the posted daily nurse staffing sheets included accurate information to include the daily census. Findings included: During an observation on 06/22/2026 at 10:13 AM, the daily staffing sheet that hung on the wall behind the front desk at the entrance station documented a census of 71.During an observation on 06/23/2026 at 11:05 AM, the same staff sheet dated 06/22/2026 was still posted on the wall. No sheet for 06/23/2026 was observed.On 06/22/2026 during the initial entrance into the facility, Administrative Staff A verified that the census was 67.During an interview on 06/23/2026 at 02:19 PM Administrative Staff A the customer service associate (CSA) updates the daily staffing sheets. He said there were three CSAs employed at the facility to ensure they would have one working every day of the week and if the CSAs were to call in, then the administrator would be responsible for updating the daily staffing sheet. He stated that if the daily staffing sheet had not been filled out correctly the CSA would need to be educated.The facility policy Posted Direct Care Daily Staffing Numbers documented that the facility would post daily for each shift nurse staffing data, including the number of nursing personnel responsible for providing direct care to residents. The information recorded on the form should include the current date (the date for which the information is posted) and the resident census at the beginning of the shift for which the information is posted. |

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| F 0851<br><br>Level of Harm - Potential for minimal harm<br><br>Residents Affected - Many | Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data.<br><br>Based on interview and record review, the facility failed to electronically submit accurate staffing information through the Payroll-Based Journaling (PBJ).Findings included:The PBJ Staffing Data Report provided by the Centers for Medicare and Medicaid Services (CMS) for the Fiscal Year (FY) 2026 Quarter 2 indicated the facility had excessive low weekend staffing.Review of the staffing sheets revealed the same number of direct care staff worked on weekends and weekdays.During an interview on 06/23/2026 at 02:19 PM Administrative Staff A verified the facility did not have low weekend staffing. He said the Director of Nursing (DON), Assistant Director of Nursing (ADON), and Minimum Data Set Nurse (MDS) worked on the weekends as needed.The Reporting Direct Care Staffing Information (Payroll Based Journal) policy, revised August 2022, documented direct care staffing information was reported electronically to CMS through the Payroll-Based Journal system. Complete and accurate direct care staffing information was reported electronically to CMS through the Payroll-Based Journal (PBJ) system in a uniform format specified by CMS. |