STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175425	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Hill Care and Rehab	251 E Wilson Avenue Spring Hill, KS 66083

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility identified a census of 36 residents. The sample included 12 residents, with five reviewed for dignity. Based on observation, record review, and interviews, the facility failed to provide a dignified care environment for Resident (R) 20. This deficient practice placed R20 at risk for impaired dignity and unmet care needs. Findings Included: - The Medical Diagnosis section within R20's Electronic Medical Records (EMR) included diagnoses of benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's Quarterly Minimum Data Set (MDS) dated 04/15/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated he used a walker for mobility. The MDs noted he was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS noted he was always incontinent of bowel and bladder, but had a toileting program. The MDS noted he had difficulty swallowing due to holding residual food in his mouth (pocketing). The MDS noted he had a mechanically altered diet. R20's Nutrition Care Area Assessment (CAA) completed 01/27/25 indicated he was at risk for weight loss and nutritional impairment. The CAA instructed staff to provide adequate intake during mealtimes. The CAA noted he was on a mechanically altered diet with thin liquids. R20's Functional Abilities CAA completed 01/27/25 indicated he required cueing during his activities of daily living (ADL) and incontinence care every two hours. R20's Care Plan initiated 03/08/22 indicated he was at risk for altered nutrition related to his cognitive impairment and medical diagnoses. The plan instructed staff to provide set-up assistance during meals. The plan indicated he required staff assistance for bed mobility, bathing, toileting, personal hygiene, transfers, and dressing. The plan indicated he had impaired cognitive function and thought processes related to his dementia. The plan instructed staff to provide consistency with caregivers and care to reduce confusion. The plan instructed staff to notify nursing if incontinent during activities and provide care as needed. (continued on next page)

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/10/25 at 09:00 AM, R20 sat in the dining room and completed his breakfast meal. R20 stood up and walked toward the dining room exit. The back of R20's pants were soaked with urine down to his knees. R20 walked to the staff and reported he was sticky and needed to be cleaned. Staff asked R20 to sit on the chair next to the nurses. R20 sat down in the chair next to the nurse's cart. R20 kept repeatedly saying loudly I'm sticky, I need help as numerous staff walked past him. R20 stood up from the chair several times while waiting for staff to come assist him. At 09:10 AM, R20 was finally escorted to his room as he continued to yell out I'm sticky, please help me. On 06/11/25 at 11:20 AM, Certified Nurse Aide (CNA) M stated staff should always assist the resident with care needs as a priority and ensure they were clean. She stated that R20 should have been provided with hygiene care immediately. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated residents should immediately provide incontinence care to avoid skin breakdown and infections. On 06/11/25 at 12:24 PM, Administrative Nurse D stated staff were expected to assist or find someone to assist residents with personal care to prevent them from waiting. She stated residents were to be provided incontinence care at the time of staff being informed. The facility's Dignity policy revised 10/2022 stated the facility was to ensure an environment that maintained and enhanced each resident's dignity and respect in full recognition of each resident's individuality.

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody. The facility identified a census of 36 residents. The sample included 12 residents, with one resident reviewed for abuse and neglect. Based on observation, record review, and interview, the facility failed to prevent an episode of resident-to-resident sexual abuse between cognitively impaired Resident (R) 21 and R17. This deficient practice placed R17 at ongoing risk for preventable abuse and mistreatment. Findings Included: - The Medical Diagnosis section within R21's Electronic Medical Records (EMR) included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), muscle weakness, repeated falls, and the need for assistance with personal care. R21's Annual Minimum Data Set (MDS) dated 04/27/25 noted a Brief Interview for Mental Status (BIMS) score of six, indicating severe cognitive impairment. The MDS indicated she had bilateral lower extremity impairments and used a wheelchair for mobility. The MDS indicated he was dependent on staff for bathing, toileting, personal hygiene, transfers, and bed mobility. The MDS indicated no behavioral concerns but indicated he displayed physically aggressive behaviors on his previous Quarterly MDS completed 01/27/25. R21's Dementia Care Area Assessment (CAA) completed 01/27/25 indicated he was dependent on staff assistance for toileting, personal hygiene, bathing, dressing, and transfers. The CAA noted he had dementia with cognitive loss. R21's Care Plan initiated on 10/04/23 indicated he was at risk for a decline in cognition, activities of daily living (ADL), falls, and incontinence related to his medical diagnoses. The plan indicated he required staff assistance for mobility in his wheelchair (10/03/23). The plan indicated he had difficulty with communication. The plan instructed staff to be conscious of his position when in groups, activities, and dining to promote proper communication with others (10/03/23). The plan noted he had a history of alleged sexual accusations (10/03/23). The plan instructed staff to anticipate his needs and provide his medications as ordered (10/03/23). The plan instructed staff to intervene as necessary to protect the rights and safety of others (10/04/23). The plan instructed staff to move him from the situation to an alternate area. The plan instructed staff to monitor his behaviors and attempt to determine an underlying cause (10/04/23). R21's plan was updated on 05/27/25 with a new intervention for sexual behaviors. The intervention instructed staff to provide medication daily. A Facility Incident Report #5635 completed on 05/27/25 revealed Licensed Nurse (LN) H walked into the television room and witnessed R21 in the television room groping R17's (Severely cognitively impaired resident) breast. The report indicated both residents were immediately separated. The note revealed that R17 was assessed with no injuries found. The report indicated both residents had no recollection of the incident when interviewed. The note revealed the medical provider, resident representative, and local law enforcement were notified. The report revealed that R21 was immediately placed on one-to-one supervision and started on medication to reduce his sexual behaviors. (continued on next page)

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F 0600 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A Witness Statement completed by LN H on 05/27/25 indicated he observed the incident and separated the two residents. LN H reported in the statement he observed R21 touching R17's breast with his left hand. LN H reported in the statement that he immediately separated the residents and assessed R17. The statement revealed that R21 was agitated when asked to not touch R17. On 06/10/25 at 07:30 AM, R21 lay in his bed. R21 had no memory of the encounter between R17 and himself. On 06/11/25 at 08:00 AM, R17 sat in her room. R17 had no memory of the encounter between R21 and herself. R17 reported she felt safe in the facility. On 06/11/25 at 11:24 AM, Certified Nurse's Aide (CNA) M stated residents with noted behaviors were not to be left alone with other residents. She stated staff were expected to monitor all residents for safety and care needs. She stated that R21 had a history of inappropriate behaviors towards females and had to be supervised. She stated the facility provided frequent dementia and abuse training for staff to complete. She stated the facility had an abuse, neglect, and exploitation (ANE) class in May 2025. On 06/11/25 at 12:24 PM, Administrative Nurse D stated R21 had inappropriate sexual behaviors toward a female. She stated residents with behaviors were to be supervised while in the common areas or placed close together. She stated that R21 had numerous behavioral incidents in the past. She stated all staff received annual ANE classes. The facility's Abuse Prevention Program revised 08/2024 indicated the facility was committed to protecting residents from abuse. The policy indicated all staff were trained to recognize and report allegations of abuse. The policy noted the facility was to provide management for dementia and behavioral symptoms for residents at risk for abuse. The policy indicated the facility promoted an environment safe for the treatment and care of the residents.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. The facility identified a census of 36 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 1's psychotropic (alters mood or thought) medication had an indication for administration. This deficient practice placed R1 at risk for ineffective treatment, unnecessary medication use, and unwarranted side effects. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN - elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), calculus (a hardened deposit, usually composed of mineral salts, that forms within the body) of the gallbladder, 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 09/19/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had received anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, diuretic (a medication to promote the formation and excretion of urine) medication, opioid (a class of controlled drugs used to treat pain) medication, and hypoglycemic (a class of medication used to lower blood sugar) medication during the observation period. The Quarterly MDS dated 02/20/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R1 had received anticoagulant medication, antidepressant medication, antianxiety medication, antiplatelet medication, diuretic medication, opioid medication, and hypoglycemic medication during the observation period. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/07/24 documented she received anticoagulant therapy and psychotropic medications with monitoring in place. R1's Care Plan, dated 10/28/22, documented staff were educated on the administration of giving medication as ordered and the five rights of medication administration. R1's EMR under the Orders tab revealed the following physician orders: Cymbalta (antidepressant) oral capsule, delayed release particles, 20 mg give one capsule by mouth daily, dated 04/22/25. The medication order lacked an indication for administration. On 06/10/25 at 08:26 AM, R1 propelled herself in her wheelchair from her room to the dining room without difficulty. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated every medication required an indication for administration. LN G stated she would clarify an order if there was no indication for administration. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected a physician's order to be followed. Administrative Nurse D stated every medication required and indication for administration. The facility's Free from Chemical Restraints, Unnecessary Psychotropic Medications policy last reviewed 04/2025 documented chemical restraints would only be used for the safety and well-being of the resident(s) and only after other alternatives have been tried unsuccessfully. Chemical restraints would only be used to treat the resident's medical symptom(s) and never for discipline or staff convenience.

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Assess the resident completely in a timely manner when first admitted, and then periodically, at least every 12 months. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 36 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to indicate on the comprehensive Minimum Data Set (MDS) that Resident (R) 33 received and required the use of a continuous positive airway pressure (CPAP- ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep). This placed R33 at risk for inaccurate reflections of the resident's status and needs to develop an individualized comprehensive plan of care. Findings included: - R33's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of acquired absence of right foot, pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral region, hematogenous osteomyelitis (a type of bone infection where bacteria travel through the bloodstream to the bones, causing inflammation and potentially bone destruction), lack of coordination, muscle weakness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12 which indicated moderately impaired cognition. The MDS documented R33 had impairment on one side of her lower extremities. The MDS documented R33 needed setup or cleanup for eating, was dependent on staff for toileting, and needed substantial/maximal assistance from staff for bathing. The MDS did not indicate R33 required the use of a CPAP. R33's Functional Abilities (self-care mobility) Care Area Assessment (CAA) dated 04/21/25 documented R33 was currently taking insulin (a hormone that lowers the level of glucose in the blood), antihypertensive (a class of medication used to treat high blood pressure), anticoagulation (blood thinner), and medication for constipation which could cause an increase in falls. The CAA documented R33 had had no falls since admission. The CAA documented R33 was dependent on staff for most activities of daily living (ADL) and required the assistance of one staff. The CAA documented R33 ambulated with a wheelchair and was dependent on staff for wheeling her chair. The CAA documented R33 currently received medication for wound healing. The CAA documented R33 was on a regular diet, with regular texture with thin liquids. The CAA documented R33 was incontinent and required a pull-up. R33's Care Plan dated 04/18/25 documented R33 was at risk for altered nutritional and hydration status related to inadequate intake and wound healing. R33's plan of care documented staff would encourage the consumption of fluids that were provided and monitor and record meal intakes. The plan of care for R33 documented staff would provide and serve supplements as ordered. R33's plan of care lacked indication of R33's CPAP. On 06/11/25 at 12:05 PM, Administrative Nurse D stated that R33 required a CPAP. Administrative Nurse D stated all CPAPs should be indicated on the MDS. (continued on next page)

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F 0636 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility Comprehensive Assessment dated 03/25 documented a comprehensive assessment of a resident's needs shall be made within fourteen days of the resident's admission. A comprehensive assessment of the resident's needs strengths, goals, life history, and preferences would be completed. A comprehensive assessment would be completed with defined significant change. Residents would receive an accurate assessment, reflective of the resident's status at the time of the assessment, by staff qualified to assess relevant care areas and knowledgeable about the resident's status, needs, strengths, and areas of decline.

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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. The facility identified a census of 36 residents. The sample included 12 residents, with five reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 20's Care Plan to remove his therapeutic diet. This deficient practice placed R20 at risk for uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R20's Electronic Medical Records (EMR) included diagnoses of benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's Quarterly Minimum Data Set (MDS) dated 04/15/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated he used a walker for mobility. The MDs noted he was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS noted he was always incontinent of bowel and bladder but had a toileting program. The MDS noted he had difficulty swallowing due to holding residual food in his mouth (pocketing). The MDS noted he had a mechanically altered diet. R20's Nutrition Area Assessment (CAA) completed 01/27/25 indicated he was at risk for weight loss and nutritional impairment. The CAA instructed staff to provide adequate intake during mealtimes. The CAA noted he was on a mechanically altered diet with thin liquids. R20's Functional Abilities CAA completed 01/27/25 indicated he required cueing during his activities of daily living (ADL) and incontinence care every two hours. R20's Care Plan initiated 03/08/22 indicated he was at risk for altered nutrition related to his cognitive impairment and medical diagnoses. The plan indicated he required a regular, mechanically soft diet with pureed meat texture and thin liquids due to his difficulty swallowing. The plan instructed staff to provide set-up assistance during meals. The plan indicated he required staff assistance for bed mobility, bathing, toileting, personal hygiene, transfers, and dressing. The plan indicated he had impaired cognitive function and thought processes related to his dementia. The plan instructed staff to provide consistency with caregivers and care to reduce confusion. The plan instructed staff to notify nursing if R20 was incontinent during activities and provide care as needed. R20's EMR under Orders revealed an active dietary order stated 05/21/25. The order indicated he received a regular, mechanically soft diet with chopped meat texture. On 06/10/24 at 12:23 PM, R20 sat at the dining room table for lunch. R20 was provided his meal. R20's meat was of chopped consistency. R20 consumed his meal with no observed swallowing concerns. Staff supervised him as he ate his meal. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/25 at 11:36 AM, Licensed Nurse (LN) G stated the care plans were updated quarterly or changed. She stated the plans were to reflect to most accurate changes related to each resident's care. She stated the plan should include the type of diet and consistency for each resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all staff had access to view the care plans. She stated the plans were reviewed by the interdisciplinary team and updated when needed. She stated the individual departments would also review the plan to ensure their areas were accurate and up to date. The facility's Comprehensive Care plan policy revised 04/2022 indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. The facility identified a census of 36 residents. The sample included 12 residents, with five reviewed for care plan revisions. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 20's Care Plan to remove his therapeutic diet. This deficient practice placed R20 at risk for uncommunicated care needs. Findings Included: - The Medical Diagnosis section within R20's Electronic Medical Records (EMR) included diagnoses of benign prostatic hyperplasia (BPH - non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dysphagia (difficulty swallowing), and dementia (a progressive mental disorder characterized by failing memory and confusion). R20's Quarterly Minimum Data Set (MDS) dated 04/15/25 noted a Brief Interview for Mental Status (BIMS) score of zero, indicating severe cognitive impairment. The MDS indicated he used a walker for mobility. The MDs noted he was dependent on staff for oral hygiene, toileting, bathing, dressing, personal hygiene, and bed mobility. The MDS noted he was always incontinent of bowel and bladder but had a toileting program. The MDS noted he had difficulty swallowing due to holding residual food in his mouth (pocketing). The MDS noted he had a mechanically altered diet. R20's Nutrition Area Assessment (CAA) completed 01/27/25 indicated he was at risk for weight loss and nutritional impairment. The CAA instructed staff to provide adequate intake during mealtimes. The CAA noted he was on a mechanically altered diet with thin liquids. R20's Functional Abilities CAA completed 01/27/25 indicated he required cueing during his activities of daily living (ADL) and incontinence care every two hours. R20's Care Plan initiated 03/08/22 indicated he was at risk for altered nutrition related to his cognitive impairment and medical diagnoses. The plan indicated he required a regular, mechanically soft diet with pureed meat texture and thin liquids due to his difficulty swallowing. The plan instructed staff to provide set-up assistance during meals. The plan indicated he required staff assistance for bed mobility, bathing, toileting, personal hygiene, transfers, and dressing. The plan indicated he had impaired cognitive function and thought processes related to his dementia. The plan instructed staff to provide consistency with caregivers and care to reduce confusion. The plan instructed staff to notify nursing if incontinent during activities and provide care as needed. R20's EMR under Orders revealed an active dietary order stated 05/21/25. The order indicated he received a regular, mechanically soft diet with chopped meat texture. On 06/10/24 at 12:23 PM, R20 sat at the dining room table for lunch. R20 was provided his meal. R20's meat was of chopped consistency. R20 consumed his meal with no observed swallowing concerns. Staff supervised him as he ate his meal. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/25 at 11:36 AM, Licensed Nurse (LN) G stated the care plans were updated quarterly or changed. She stated the plans were to reflect the most accurate changes related to each resident's care. She stated the plan should include the type of diet and consistency for each resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all staff had access to view the care plans. She stated the plans were reviewed by the interdisciplinary team and updated when needed. She stated the individual departments would also review the plan to ensure their areas were accurate and up to date. The facility's Comprehensive Care Plan policy revised 04/2022 indicated each resident was to have a comprehensive assessment and provided individualized interventions to reflect their treatment needs. The policy indicated the care plans were reviewed and updated to reflect changes that may occur with the resident's goals and care needs.

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care and assistance to perform activities of daily living for any resident who is unable. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 36 residents. The sample included 12 residents, with one resident reviewed for activities of daily living (ADL) care. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 9 with assistance with eating and further failed to ensure R9's call light was within his reach. This defiant practice placed R9 at risk of aspiration and unmet needs. Findings included: - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body)following cerebrovascular accident (CVA-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) effecting left non-dominant side, pulmonary edema (accumulation of extravascular fluid in the lung tissues), pain, obesity (excessive calories), dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), sleep apnea (a disorder of sleep characterized by periods without respirations), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), contracture (abnormal permanent fixation of a joint or muscle) left hand, elbow and shoulder, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and respiratory failure with hypoxia (occurs when the lungs were unable to adequately provide oxygen to the bloodstream, leading to low oxygen levels in the blood). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) should not be conducted, and that R9 was rarely or never understood. MDS documented R9 was dependent on staff for all activities of daily living (ADL) except eating and needed setup or cleanup from staff. The MDS documented R9 had impairment on one side of his upper body, and both sides of his lower body. R9's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 01/24/25 documented R9 required supervision while eating related to being on a mechanically altered diet. The CAA documented R9 could feed himself and required set-up and clean-up assistance. R9 was dependent on staff for all care, hygiene, toileting hygiene, wheeling the wheelchair, bathing, dressing the upper and lower body, and applying footwear. The resident currently had shown a decline in ADLs and had chosen Hospice services. R9's Care Plan dated 01/14/25 documented R9 preferred to eat in his room, and R9 preferred to stay in his room most of the time. R9's plan of care documented on 09/16/24 R9 spilled hot water on himself. R9's plan of care dated 07/15/24 documented R9 required supervisor/touching assistance with eating. R9's plan of care documented R9 used a trapeze above his bed to assist in repositioning, and staff were to maintain the call bell within his reach. R9's EMR under Orders documented the following physician's order: Elevate the head of bed thirty-forty-five degrees to prevent/treat shortness of breath while he laid in bed every shift for respiratory failure and pulmonary edema, dated 09/23/23. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Hill Care and Rehab	251 E Wilson Avenue Spring Hill, KS 66083

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F 0677 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/25 at 09:34 AM, R9 was laid flat in his bed on his back. R9 had a bowl of oatmeal trying to spoon the oatmeal to his mouth. R9's call light was wrapped around his trapeze arm, out of R9's reach. R9 had no staff assistance in his room to help or monitor his eating. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated call lights should always be within the resident's reach. LN G stated all residents should be raised as high as the resident could be when eating alone in their bed. She stated a resident's bed should never be laid flat when a resident was eating. On 06/11/25 at 11:53 AM, Certified Nurse Aide (CNA) M stated the CNAs and sometimes kitchen staff delivered meals to the residents' rooms. CNA M stated residents should not be laid flat when they are eating. She stated call lights should always be laid on the resident or where the resident could reach it if needed. On 06/11/25 at 12:05 PM, Administrative Nurse D stated resident's bed should be elevated when a resident was eating in bed, never laid flat. Administrative Nurse D stated call lights should be within the resident's reach. The facility's Quality of Life policy dated 04/25 documented the community environment and staff behaviors were directed toward assisting the resident in maintaining and or achieving independent functioning dignity and well-being. Residents who were unable to carry out activities of daily living receive the necessary care and services to maintain good nutrition grooming and personal and oral hygiene.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 36 residents. The sample included 12 residents, with three reviewed for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction). Based on interviews, observations, and record reviews, the facility failed to ensure Resident (R) 27's pressure-reducing low air-loss mattress (specialized air mattress used to reduce the pressure applied to the body) was utilized per her weight and manufacturer's safe use recommendations. The facility additionally failed to apply R9's pressure-reducing boots, which were used to off-load the heels of his feet per his care plan. These deficient practices placed both residents at risk for preventable wounds and impaired wound healing. Findings included: - The Medical Diagnosis section within R27's Electronic Medical Records (EMR) included diagnoses of major depressive disorder (major mood disorder), muscle failure, and kyphosis (abnormal spinal curvature in the upper back). R27's Annual Minimum Data Set (MDS) dated 03/27/25 noted a Brief Interview for Mental Status (BIMS) score of 13, indicating mild cognitive impairment. The MDS noted she required partial to moderate assistance from staff for bed mobility, transfers, bathing, dressing, toileting, and personal hygiene. The MDS noted she was at risk for developing a pressure ulcer. The MDS noted she had no unhealed pressure ulcers. The MDS noted she had pressure-relieving devices for her wheelchair and bed. R27's previous Quarterly MDS completed 02/08/25 noted she had an unhealed stage-two (partial-thickness skin loss into but no deeper than the dermis including intact or ruptured blisters) pressure injury. R27's Pressure Ulcer Care Area Assessment (CAA) completed 03/25/25 indicated she was at risk for skin breakdown and pressure ulcers related to her limited mobility, history of pressure ulcers, and medical diagnoses. The CAA noted the facility would implement care-planned interventions to minimize the risks. R27's Care Plan initiated 05/27/24 indicated she had activities of daily living (ADL) self-care deficit. The plan indicated she required partial to moderate assistance from staff for toileting, bathing, transfers, bed mobility, dressing, and personal hygiene. The plan indicated she had bladder incontinence and was at risk for skin impairments. The plan instructed staff to provide a two-hour incontinence check and skin monitoring. The plan lacked documentation related to her risks for pressure ulcers or the use of her low air-loss mattress. R27's EMR under Assessments revealed a Braden Scale assessment completed on 03/28/25. The assessment revealed a score of 11 indicating she was at high risk for the development of pressure ulcers. R27's EMR under Weekly Skin Evaluation revealed she had a reddened area on her thoracic spine area (mid-back spine) that was resolving. R27's EMR under Vitals revealed she weighed 86.1 pounds (lbs.) on 06/04/25. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	A review of the low air-loss mattress manufacturer's operation (ProActive Protekt Aire 6000) manual indicated the mattress system was intended to reduce the incidence of pressure ulcers while optimizing comfort. The manual indicated the mattress pump's pressure levels and firmness were preset based on the weight range selected. The manual revealed that using the mattress while deflated placed the resident at risk for injuries. On 06/09/25 at 08:21 AM, R27 sat in her bed. The head of her bed was raised above 45 degrees as she ate her breakfast. R27's low air-loss mattress was set to 180 lbs. The mattress pump had fixed weight settings of 80lbs, 130lbs, 180lbs, 230lbs, 280lbs, 340lbs, 400lbs, and 450lbs. On 06/10/24 at 10:11 AM, R27 slept in her bed. Her mattress pump was set to 180lbs. On 06/11/25 at 10:32 AM, R27 sat in her bed as she colored in her sketchbook. She sat upright with the head of her bed raised over 45 degrees. R27's air mattress was deflated, and the low air-loss control panel was off. R27 sat directly on the frame of the bed. She stated she was not sure how long the bed was off but thought staff turned it back on when she left the room earlier in the morning. On 06/11/25 at 10:34 AM, Certified Medication Aide (CMA) entered the room and checked the bed control. She turned the panel on and stated she was not sure why the panel was off. She stated staff were expected to check the bed each shift and set it to R27's weight. On 06/11/25 at 12:05 PM, Administrative Nurse D stated the low air-loss mattresses were to be set according to the resident's weight and checked each time staff entered the room. The facility's Prevention of Pressure Injuries policy revised 08/2022 indicated the facility was to identify and implement preventative interventions for residents at risk for pressure injuries. The policy indicated the facility was to implement and provide ongoing monitoring for wound care and preventative services to ensure effective treatment and wound prevention.- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body) following cerebrovascular accident (CVA-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) effecting left non-dominant side, pulmonary edema (accumulation of extravascular fluid in the lung tissues), pain, obesity (excessive calories), dementia (a progressive mental disorder characterized by failing memory and confusion), hypertension (high blood pressure), sleep apnea (a disorder of sleep characterized by periods without respirations), contracture (abnormal permanent fixation of a joint or muscle) of left hand, elbow and shoulder, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and respiratory failure with hypoxia (occurs when the lungs were unable to adequately provide oxygen to the bloodstream, leading to low oxygen levels in the blood). The Significant Change Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) should not be conducted. The MDS documented R9 was rarely or never understood. The MDS documented R9 was dependent on staff for all activities of daily living (ADL) except eating and needed setup or cleanup. The MDS documented R9 had impairment on one side of his upper body, and both sides of his lower body. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R9's Pressure Injury/Ulcer Care Area Assessment (CAA) dated 01/24/25 documented R9 was always incontinent of both bowel and bladder. The CAA documented R9 required assistance with all care. The CAA documented R9 was seen by the wound physician weekly, with daily dressing changes. The CAA documented R9 was admitted to Hospice services. R9's Care Plan dated 04/05/23 documented R9 had a low air loss mattress with bolsters, staff were to check low air loss mattress for proper setting according to R9's weight. R9's plan of care documented R9 had a pressure-reducing wheelchair cushion. R9's plan of care dated 06/23/24 documented R9 had a potential and actual impairment to skin integrity related to immobility and fragile skin. R9's plan of care documented staff were to encourage and assist in turning and repositioning at least every two hours and as needed for comfort and to offload pressure. R9's Braden Scale for Prediction Pressure Sore Risk dated 04/15/25 documented a score of 13 indicating a moderate risk for pressure ulcers. R9's Weekly Wound Assessment dated 06/04/25 documented R9 had a left lateral malleolus wound. R9's physician's orders under the Orders tab revealed the following orders: Apply barrier cream to buttock one time a day for wound healing and as needed (PRN), dated 05/07/25. Cleanse right lower leg distal/lateral ankle with cleanser and apply Skin-prep (liquid skin protectant) to peri-wound. Apply Medi honey (wound dressing), then calcium alginate (highly absorbent dressing), and cover with a foam dressing one time a day for skin integrity, and as needed (PRN), dated 05/28/25. On 06/09/25 at 07:24 AM, R9 laid on his back on his bed. R9's heels were directly on his low air loss mattress. R9 had heel protector boots, one on the right-side bottom of his bed and one on the left-side bottom of his bed. On 06/10/25 at 07:50 AM, R9 laid on his back on his bed. R9's heels laid directly on his low air-loss mattress. One of R9's heel protector boots laid on his bedside table. On 06/11/25 at 7:26 AM, R9 laid on his back on his bed. R9's heels laid directly on the mattress. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated she did remind CNAs to ensure residents with wounds, or the residents that need their heels elevated have their heels elevated. LN G stated it was the nurse's responsibility to ensure boots were placed on the residents. LN G stated R9 needed to have his heels floated when in bed. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated if a resident needed boots on, or their heels floated, the nurse would let the CNAs know. CNA M stated the nurse also ensured heels were floating. On 06/11/25 at 12:05 PM, Administrative Nurse D stated the CNAs and nursing knew what residents needed to have their heels floated. Administrative Nurse D stated it was the responsibility of all nursing staff to ensure heels were floated or boots were on the resident when the resident was in bed. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Prevention of Pressure Injuries policy dated 10/24 documented the facility would identify specific risk factors and establish goals and prevention interventions with the physician's input. The facility would establish approaches to identify, stabilize, or minimize risk factors associated with pressure injuries.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. The facility had a census of 36 residents. The sample included 12 residents, with three reviewed for accidents. Based on observation, record review, and interview, the facility failed to secure pressurized supplemental oxygen tanks in a safe, locked area, and out of reach of the 22 cognitively impaired independently mobile residents. The facility additionally failed to ensure fall interventions were in place for Resident (R) 12 and R4. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings included: - On 06/11/25 at 07:58 AM, a walkthrough of the facility revealed an unsecured oxygen storage room. The room contained 35 pressurized supplemental oxygen cylinder tanks stored in floor racks. The room had a key lock on the entry door. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated oxygen should be stored in a locked room in a storage rack. On 06/11/25 at 11:52 AM, Certified Nurse Aide (CNA) M stated oxygen tanks should be stored in a locked room in storage racks. On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected oxygen tanks would be stored in a locked room. The facility's Fire Safety Precaution Including Oxygen Storage policy last revised 04/2025 documented personnel would follow the facility's established fire safety precautions in order to provide safety to all concerned. - R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Significant Change Minimum Data Set (MDS) dated 01/17/25 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R12 was dependent on staff assistance for transfers, dressing, and personal hygiene. The MDS documented R12 was on hospice services. The Quarterly MDS dated 04/29/25 documented a BIMS score of zero, which indicated severely impaired cognition. The MDS documented that R12 was dependent on staff assistance for bed mobility, dressing, personal hygiene, and transfers. The MDS documented R12 was on hospice services. R12's Falls Care Area Assessment (CAA) dated 02/07/25 documented she was dependent on a wheelchair for mobility related to her physical status of a fractured left hip and was on hospice services. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	R12's Care Plan, initiated date of 09/24/18 and a revision date of 01/19/23, documented staff would keep the call light within reach. The plan of care documented staff would provide R12 with frequent education about how to use the call light and keep the call light secured and within reach. The plan of care dated 12/19/24 documented R12 had an injury fall on 12/18/24 and the intervention that was implemented was staff would remove the Hoyer (total body mechanical lift) sling after each use from under R12. The plan of care with an initiated date 04/22/25 documented R12 had an injury fall. The intervention that was implemented was staff would recline her in the Broda chair (specialized wheelchair with the ability to tilt and recline) after she was finished eating. The plan of care also documented Dycem (a non-slip mat used for stabilization and gripping to prevent slipping) would be placed in her chair. The plan of care dated 06/05/25 documented R12 had an injury fall and the intervention implemented was the staff would ensure her bed was in the lowest position and a floor mat was in place next to the bed. On 06/09/25 at 08:15 AM, R12 laid on her back in bed. R12 call light was on the floor behind her bed. R12's floor mat was folded up and stood upright away from her bed. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated all staff have access to each resident's care plan. LN G stated it was all nursing staff's responsibility to ensure fall interventions were in place before leaving a resident's room. LN G stated staff could review the resident's fall interventions from the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated she did have access to the resident's care plans. CNA M stated if a new intervention for a fall was put in place the director of nursing would come to the floor and let all staff know. CNA M stated it was the CNA's job to ensure the interventions for falls were put in place before leaving the resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all nursing staff have access to the care plans. Administrative Nurse D stated she would expect the person who laid the resident down to ensure all fall interventions were put in place before leaving the resident's room. The facility's Falls and Fall Risk Managing policy dated 04/24 documented based on previous evaluations and current data, the staff would identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling. - R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), hypertension (high blood pressure), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), hyperlipidemia (condition of elevated blood lipid levels), dementia (a progressive mental disorder characterized by failing memory and confusion), hemiparesis/hemiplegia (weakness and paralysis on one side of the body), following 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), pain, insomnia (inability to sleep), anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), 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), and mood disorder (category of mental health problems, feelings of sadness, helplessness, guilt, and wanting to die were more intense and persistent than what may normally be felt from time to time). (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly Minimum Data Set (MDS) for R4 dated 03/24/25 recorded a Brief Interview for Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R4 needed setup or cleanup for eating and substantial to maximal assistance from staff for toileting and bathing. The MDS documented R4 had falls since admission. The MDS documented R4 had two non-injury falls. R4's Falls Care Area Assessment (CAA) dated 12/22/24 documented R4's fall CAA triggered related to R4 taking an antidepressant (a class of medications used to treat mood disorders) routinely. R4's Care Plan dated 03/14/23 documented R4 had a non-injury fall and staff would place her call light within her reach. R4's plan of care dated 09/05/24 documented a non-injury fall and the facility would place nonskid strips in front of her toilet. R4's plan of care dated 05/05/25 documented R4 was at risk for falls and has had an actual fall related to sliding out of her bed, R4's bed would be placed in a low position, a fall mat would be placed beside her bed, and her wheelchair would be placed at the bedside. On 06/09/25 at 07:34 AM, R4 laid on her bed, R4's bed was in a low position. R4's call light laid on the floor, and her fall mat was folded up at the top of her bed. R4 did not have nonskid strips in her bathroom. On 06/10/25 at 02:07 PM, R4 laid in on her bed. R4's bed was at waist height. R4's fall mat was folded up at the head of her bed. R4 did not have nonskid strips on her bathroom floor. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated all staff have access to each resident's care plan. LN G stated it was all nursing staff's responsibility to ensure fall interventions were in place before leaving a resident's room. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated she did have access to the resident's care plans. CNA M stated if a new intervention for a fall was put in place the director of nursing would come to the floor and let all staff know. CNA M stated it was the CNA's job to ensure the interventions for falls were put in place before leaving the resident. On 06/11/25 at 12:05 PM, Administrative Nurse D stated all nursing staff have access to the care plans. Administrative Nurse D stated she would expect the person who laid the resident down to ensure all fall interventions were put in place before leaving the resident's room. The facility's Falls and Fall Risk Managing policy dated 04/24 documented based on previous evaluations and current data, the staff would identify interventions related to the residents' specific risks and causes to try to prevent the resident from falling and to try to minimize complications from falling.

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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 identified a census of 36 residents. The sample included 12 residents, with two residents reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 33's continuous positive airway pressure (CPAP - ventilation device that blows a gentle stream of air into the nose to keep the airway open during sleep) mask was stored in a sanitary manner. This placed R33 at an increased risk for respiratory infection and complications. Findings included: - R33's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of the acquired absence of right foot, pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) of sacral region, hematogenous osteomyelitis (a type of bone infection where bacteria travel through the bloodstream to the bones, causing inflammation and potentially bone destruction), lack of coordination, muscle weakness, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of 12, which indicated moderately impaired cognition. The MDS documented R33 had impairment on one side of her lower extremities. The MDS documented R33 needed setup or cleanup for eating, was dependent on staff for toileting, and needed substantial to maximal assistance from staff for bathing. The MDS did not indicate R33 required the use of a CPAP. R33's Functional Abilities (self-care mobility) Care Area Assessment (CAA) dated 04/21/25 documented R33 was currently taking insulin (a hormone that lowers the level of glucose in the blood), antihypertensive (a class of medication used to treat high blood pressure), anticoagulation (blood thinner), and medication for constipation which could cause an increase in falls. The CAA documented R33 had had no falls since admission. The CAA documented R33 was dependent on staff for most activities of daily living (ADL) and required the assistance of one staff. The CAA documented R33 ambulated with a wheelchair and was dependent on staff for wheeling her chair. The CAA documented R33 received medication for wound healing. The CAA documented R33 was on a regular diet, with regular texture with thin liquids. The CAA documented R33 was incontinent and required a pull-up. R33's Care Plan dated 04/18/25 documented R33 was at risk for altered nutritional and hydration status related to inadequate intake and wound healing. R33's plan of care documented staff would encourage the consumption of fluids that were provided and monitor and record meal intakes. The plan of care for R33 documented staff would provide and serve supplements as ordered. R33's plan of care lacked indication of R33's CPAP. R33's EMR under the Orders tab lacked staff direction for the use, and cleaning of CPAP and lacked staff direction for sanitary storage of CPAP. (continued on next page)

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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Hill Care and Rehab	251 E Wilson Avenue Spring Hill, KS 66083

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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 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R33's EMR under Progress Notes dated 05/29/25 documented Licensed Nurse (LN) received a call from the X-ray department for a follow-up on R33's chest X-ray findings. The findings indicated left basal infiltrate/effusion (abnormal accumulation of fluid or other substances in the lower part(basal)of the lungs, specifically within the lung tissue (infiltrate) or in the space around the lungs(effusion). LN called the physician on call and received an order for the facility to continue Levaquin (antibiotic) as ordered. On 06/09/25 at 07:57 AM, R33 laid on her right side in her bed. R33's CPAP mask was draped over the CPAP machine without a clean barrier and sanitary container. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated CPAP mask should be cleaned, air-dried, and placed in a plastic bag. LN G stated R33 used a CPAP. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated the CPAP mask should be placed in a drawer. She stated the nurse on duty usually took care of the respiratory equipment. On 06/11/25 at 02:05 PM, Administrative Nurse D stated it was all nursing staff's duty to ensure all respiratory equipment was placed in a bag in a sanitary manner. The facility did not provide a respiratory storage policy.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility identified a census of 36 residents. The sample included 12 residents. Based on observation, record review, and interview the facility failed to post its updated daily posted staffing sheet. Findings included: - On 06/09/25 at 07:04 AM an inspection of the facility revealed the facility's Direct Care Report form posted on the wall across from the nurse's station. The form was dated 06/06/25. On 06/09/25 at 07:04 AM, Licensed Nurse (LN) I stated nursing staff were responsible for updating the form each day and posting it. On 06/11/25 at 12:24 PM, Administrative Nurse D stated the charge nurse was responsible for creating and posting the staffing form each day. A review of the facility's Staffing policy revised 11/2023 indicated that staffing hours must be maintained for facility records for a minimum of 18 months. The policy indicated the records must be made available upon request.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 36 residents. The sample included 12 residents, with two residents reviewed for dementia (a progressive mental disorder characterized by failing memory and confusion) care. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 17 with dementia services related to supervision and accidents. The defiant practice placed R17 at risk for preventable accidents. Findings Included: - R17's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of a history of falls, muscle weakness, hypothyroidism (a condition characterized by decreased activity of the thyroid gland), insomnia (inability to sleep), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), unsteadiness on feet, and peripheral vascular disease (PVD - slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel). The Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of zero, which indicated severely impaired cognition. The MDS documented R17 needed set-up or clean-up assistance with eating, and substantial/maximal assistance from staff for toileting and bathing. The MDS documented R17 had a fall since admission and had two or more non-injury falls. R17's Communication Care Area Assessment (CAA) dated 03/23/25 documented R17's CAA related to R17 not understanding others, and others not understanding her. The CAA documented R17 was alert to herself only. R17's Care Plan dated 07/02/19 documented staff were to keep R17's call light within her reach. R17's plan of care dated 05/29/23 documented a non-injury fall related to R17 walking unassisted and without calling for assistance, the intervention for the fall was to keep R17's door open, for staff to easily view R17. A Facility Incident Report #5635 completed on 05/27/25 revealed Licensed Nurse (LN) H walked into the television room and witnessed R17 (Severely cognitively impaired resident) in the television room with R21. LN H witnessed R21 groping R17's breast. The report indicated both residents were immediately separated. The note revealed that R17 was assessed with no injuries found. The report indicated both residents had no recollection of the incident when interviewed. The note revealed the medical provider, resident representative, and local law enforcement were notified. The report revealed that R21 was immediately placed on one-to-one supervision and started on medication to reduce his sexual behaviors. A Witness Statement completed by LN H on 05/27/25 indicated he observed the incident and separated the two residents. LN H reported in the statement he observed R21 touching R17's breast with his left hand. LN H reported in the statement that he immediately separated the residents and assessed R17. The statement revealed that R21 was agitated when asked to not touch R17. (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/09/25 at 07:28 AM, R17's laid on her bed, and R17's call light laid on the floor. R17's call light was not within her reach. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated residents with dementia should be left alone and should be monitored frequently. LN G stated call lights should always be within the resident's reach. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated residents with dementia should be checked on frequently. CNA M stated resident's call light should be laid on the resident, always within the resident's reach. On 06/11/25 at 12:05 PM, Administrative Nurse D stated that residents with dementia should be monitored. Administrative Nurse D stated call lights should be within the resident's reach. The facility's Dementia Care of the Resident policy dated 10/24 documented that residents with diagnosed dementia or displays symptoms of dementia would receive necessary care and services to maintain or attain their highest practicable physical, mental, and psychosocial well-being.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. The facility identified a census of 36 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the Consultant Pharmacist (CP) identified and reported irregularities in Resident (R) 1's medication which lacked an indication for administration. The facility also failed to ensure the CP identified and reported the physician's order for monitoring the pulse for an antihypertensive (a class of medication used to treat high blood pressure) medication. This deficient practice placed R1 at risk for unnecessary medication use, side effects, and physical complications. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN - elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), calculus (a hardened deposit, usually composed of mineral salts, that forms within the body) of the gallbladder, 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 09/19/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had received anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, diuretic (a medication to promote the formation and excretion of urine) medication, opioid (a class of controlled drugs used to treat pain) medication, and hypoglycemic (a class of medication used to lower blood sugar) medication during the observation period. The Quarterly MDS dated 02/20/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R1 had received anticoagulant medication, antidepressant medication, antianxiety medication, antiplatelet medication, diuretic medication, opioid medication, and hypoglycemic medication during the observation period. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/07/24 documented she received anticoagulant therapy and psychotropic medications with monitoring in place. R1's Care Plan, dated 10/28/22, documented staff were educated on the administration of giving medication as ordered and the five rights of medication administration. R1's EMR under the Orders tab revealed the following physician orders: Ursodiol, (medication used to dissolve gallstones) oral capsule 300 milligrams (mg) give one capsule by mouth three times a day, dated 04/8/25. The medication order lacked an indication for administration. Tamsulosin (medication used to assist with the output of urine) capsule 0.4 mg, give one capsule by mouth daily, dated 04/8/25. The medication order lacked an indication for administration. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Cymbalta (antidepressant) oral capsule, delayed release particles, 20 mg give one capsule by mouth daily, dated 04/22/25. The medication order lacked an indication for administration. Metoprolol succinate (antihypertensive) tablet extended release 24-hour 25 mg give one tablet by mouth daily for HTN, hold for systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) less than (<) 110 millimeters (mm) of mercury (Hg) and a heart rate < 60 beats per minute. Do not crush medication, dated 04/09/25. Review of R1's Medication Administration Record (MAR), Treatment Administration Record (TAR), and her EMR from 03/01/25 to 06/09/25 (100 days) lacked heart monitoring as ordered by the physician for antihypertensive medication Metoprolol revealed for 61 days. The MMR's lacked evidence of the CP identified the lack of indication for medication administration. Review of the Monthly Medication Review (MMR) from June 2024 to May 2025 documented recommendations from March 2023 to review antihypertensive medication orders for hold parameters and physician notification. The MMR's lacked CP noted the irregularities of no indication for medication administration and heart monitoring for antihypertensive medication. On 06/10/25 at 08:26 AM, R1 propelled herself in her wheelchair from her room to the dining room without difficulty. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated every medication required an indication for administration. LN G stated she would clarify an order if there was no indication for administration. LN G stated if the physician had a specific parameter for monitoring a resident's heart rate, then the heart rate should be obtained prior to medication administration. On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected a physician's order to be followed. Administrative Nurse D stated if the physician had ordered a heart rate to monitor for hypertensive medication, she expected the heart rate to be obtained prior to medication administration. Administrative Nurse D stated every medication required and indication for administration. The facility's Medication Regimen Reviews policy last reviewed 02/2025 documented the Consultant Pharmacist would review the medication regimen per state and federal guidelines. The policy directed reporting of irregularities to the attending physician, the facility medical director, and the director of nursing.

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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. The facility identified a census of 36 residents. The sample included 12 residents, with five residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure physician parameters were followed for a hypertensive medication (class of medication used to treat hypertension (high blood pressure) for Resident (R) 1. The facility also failed to ensure R1's medication had an indication for administration. These deficient practices placed R1 at risk for the potential of unnecessary medication administration thus leading to possible harmful side effects. Findings included: - R1's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (HTN - elevated blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), calculus (a hardened deposit, usually composed of mineral salts, that forms within the body) of the gallbladder, 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 09/19/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R1 had received anticoagulant (a class of medications used to prevent the blood from clotting) medication, antidepressant (a class of medications used to treat mood disorders) medication, antianxiety (a class of medications that calm and relax people) medication, antiplatelet (medication that helps prevent blood clots from occurring) medication, diuretic (a medication to promote the formation and excretion of urine) medication, opioid (a class of controlled drugs used to treat pain) medication, and hypoglycemic (a class of medication used to lower blood sugar) medication during the observation period. The Quarterly MDS dated 02/20/25 documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R1 had received anticoagulant medication, antidepressant medication, antianxiety medication, antiplatelet medication, diuretic medication, opioid medication, and hypoglycemic medication during the observation period. R1's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) dated 10/07/24 documented she received anticoagulant therapy and psychotropic medications with monitoring in place. R1's Care Plan, dated 10/28/22, documented staff were educated on the administration of giving medication as ordered and the five rights of medication administration. R1's EMR under the Orders tab revealed the following physician orders: Ursodiol (medication used to dissolve gallstones) oral capsule 300 milligrams (mg) give one capsule by mouth three times a day, dated 04/8/25. The medication order lacked an indication for administration. Tamsulosin (medication used to assist with the output of urine) capsule 0.4 mg, give one capsule by mouth daily, dated 04/8/25. The medication order lacked an indication for administration. (continued on next page)

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Metoprolol succinate (antihypertensive) tablet extended release 24-hour 25 mg give one tablet by mouth daily for HTN, hold for systolic blood pressure (SBP - top number, the force your heart exerts on the walls of your arteries each time it beats) less than (<) 110 millimeters (mm) of mercury (Hg) and a heart rate < 60 beats per minute. Do not crush medication, dated 04/09/25. Review of R1's Medication Administration Record (MAR), Treatment Administration Record (TAR), and her EMR from 03/01/25 to 06/09/25 (100 days) lacked heart monitoring as ordered by the physician for antihypertensive medication Metoprolol revealed for 61 days. The MMR's lacked evidence of the CP identified the lack of indication for medication administration. Review of the Monthly Medication Review (MMR) from June 2024 to May 2025 documented recommendations from March 2023 to review antihypertensive medication orders for hold parameters and physician notification. The MMR's lacked CP noted the irregularities of no indication for medication administration and heart monitoring for antihypertensive medication. On 06/10/25 at 08:26 AM, R1 propelled herself in her wheelchair from her room to the dining room without difficulty. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated every medication required an indication for administration. LN G stated she would clarify an order if there was no indication for administration. LN G stated if the physician had a specific parameter for monitoring a resident's heart rate, then the heart rate should be obtained prior to medication administration. On 06/11/25 at 12:05 PM, Administrative Nurse D stated she expected a physician's order to be followed. Administrative Nurse D stated if the physician had ordered a heart rate to monitor for hypertensive medication, she expected the heart rate to be obtained prior to medication administration. Administrative Nurse D stated every medication required and indication for administration. The facility's Unnecessary Medications policy last reviewed 04/2025 documented the resident's drug regimen would be free from unnecessary drugs. Residents or their representatives had the right to refuse ordered medications. Unnecessary Drug - was any drug used in excessive dose, including duplicative therapy or for excessive duration, or without adequate monitoring or without adequate indications for its use or in the presence of adverse consequences which indicate the dose should be reduced or discontinued or any combination of the reasons above. Adequate Indications for Use - refers to the identified, documented clinical rationale for administering a medication that was based upon an assessment of the resident's condition and therapeutic goals, and after any safer treatments have been deemed clinically contraindicated. Also, adequate indication for use means that the medication administered was consistent with the manufacturer's recommendations and/or clinical practice guidelines, clinical standards of practice, medication references, clinical studies, or evidence-based review articles that are published in medical and/or pharmacy journals.

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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 identified a census of 36 residents. The facility failed to provide the services of a full-time certified dietary manager for the 36 residents who resided in the facility and received their meals from the kitchen. This placed the residents at risk for inadequate nutrition. Findings included: - On 09/09/25 at 08:23 AM, Dietary Staff BB stated she was currently in class to become a Certified Dietary Manager (CDM). Dietary Staff BB stated the Registered Dietician (RD) came to the facility monthly. The facility's Food Service Staffing policy last reviewed 10/2024 documented the facility would employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service.

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F 0838 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. The facility identified a census of 36 residents. The sample included 12 residents. Based on observations, interviews, and record reviews, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. This failure affected all 36 residents residing in the facility. Findings Included: - On 06/09/25 Administrative Staff A provided a Facility Assessment updated 12/2024. A review of the assessment revealed the following: The assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse Aides (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift, day, and weekend. On 06/09/25 a review of the facility's Payroll Based Journaling (PBJ - Staffing Data Report) from 04/01/24 to 03/31/25 revealed excessively low weekend staffing triggered on Quarter Three (04/01/24 to 06/30/24) and Quarter Four (07/01/24 to 09/30/24). On 06/11/24 at 12:24 PM, Administrative Nurse D stated the facility assessment update was completed recently by the management team. She stated the assessment should include the staffing requirements. On 06/11/24 at 01:22 PM, Administrator A stated the assessment was recently updated to include the staffing requirement put out by the Centers for Medicare and Medicaid Services (CMS). The facility's Facility Assessment policy revised 01/2017 indicated the facility would conduct and document a facility-wide assessment to determine what resources were necessary to care for the residents during day-to-day operations including evenings, nights, and weekends.

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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. The facility identified a census of 36 residents. The sample included 12 residents, with two residents reviewed for hospice services. Based on observation, record review, and interviews, the facility failed to provide a description of the medication and equipment provided to Resident (R) 12 by hospice. This deficient practice created a risk for missed or delayed services, impaired physical, and psychosocial care for R12. Findings included: - R12's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness). The Significant Change Minimum Data Set (MDS) dated 01/17/25 documented a Brief Interview of Mental Status (BIMS) score of six, which indicated severely impaired cognition. The MDS documented R12 was dependent on staff assistance for transfers, dressing, and personal hygiene. The MDS documented R12 was on hospice services. The Quarterly MDS dated 04/29/25 documented a BIMS score of zero, which indicated severely impaired cognition. The MDS documented that R12 was dependent on staff assistance for bed mobility, dressing, personal hygiene, and transfers. The MDS documented R12 was on hospice services. R12's Cognitive Loss/Dementia Care Area Assessment (CAA), dated 02/07/25 documented she was dependent on a wheelchair for mobility related to her physical status of a fractured left hip and was on hospice services. R12's Care Plan, dated 01/14/25 documented the nursing staff would notify the hospice provider of any changes in R12's condition. The plan of care documented hospice would provide nursing visits two times weekly and as needed, a bath aide would visit two times weekly, social services would visit monthly and as needed, and the chaplain would visit monthly and as needed. R12's EMR under the Orders tab revealed the following physician orders: Admit to hospice with a diagnosis of senile degeneration of the brain, dated 01/14/25. On 06/09/25 at 08:15 AM, R12 laid on her back in bed. R12 call light was on the floor behind her bed on the floor. R12's floor mat was folded up and stood upright away from her bed. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated hospice provider supplied a notebook for each resident on hospice services. LN G stated she would refer to the notebook provided by hospice for any information concerning R12's hospice care. LN G stated the hospice information should also be on R12's person-centered care plan. LN G stated R12's care plan should include the equipment supplied and medication covered by the hospice provider. (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/11/25 at 11:52 AM, Certified Nurse Aide (CNA) M stated she would know which residents were on hospice services if there was a hospice notebook in the cupboard at the nurse's station. CNA M stated the items provided by the hospice provider should be included in the resident's care plan. On 06/11/25 at 12:05 PM, Administrative Nurse D stated everyone had access to the resident's care plans and their Kardex (a nursing tool that gives a brief overview of the care needs of each resident). Administrative Nurse D stated the hospice information should be the resident's care plan with the information of what services, supplies, and equipment that was provided by hospice. The facility's Hospice Program policy last reviewed 10/2024 documented the facility may contract for hospice services for residents who wish to participate in such programs, including services that would be provided and the coordination of services. The facility may limit the hospice providers as related to the coordination and communication of care within the community.

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F 0851 Level of Harm - Potential for minimal harm Residents Affected - Many	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility reported a census of 36 residents. The sample included 12 residents. Based on record review and interviews, the facility failed to submit accurate staffing information to the federal regulatory agency through Payroll Based Journaling (PBJ - Staffing Data Report), when the facility failed to submit accurate weekend staffing coverage hours. This placed the residents at risk for unidentified and ongoing inadequate staffing. Findings included: - A review of the facility's submitted PBJ data from 04/01/24 through 03/31/25 indicated the facility triggered for excessively low weekend staffing for Fiscal Year (FY) Quarter Three (04/01/24 to 06/30/24) and FY Quarter Four (07/01/24 to 09/30/24). A review of the facility's working schedule, time sheets/punches, and posted staffing hours indicated no gaps or loss of hours. On 06/09/25, a review of the Facility Assessment updated 12/2024 revealed the assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aide (CNA) needed for each unit, patient acuity, and census. The assessment lacked staffing levels required for each shift, day, and weekend. On 06/11/25 at 11:30 AM, Licensed Nurse (LN) G stated she worked weekends and didn't have concerns related to low weekend staffing. She stated the nurse manager would come in and help if the staff called off. On 06/11/25 at 12:24 PM, Administrative Nurse D stated the facility had gaps in staffing or issues with weekend staffing. She stated the facility provided incentives for staff to pick up extra shifts and other staff could cover any open shift. On 06/11/25 at 01:04 PM, Administrator A stated the facility recently switched to a new tracking system but the facility has been adequately staffed. He stated the facility has been triggered for low weekend staffing several times when the facility had no issues with staffing. The facility's Payroll-Based Journaling policy revised 11/2017 indicated staffing and census information will be reported electronically to the Centers for Medicare and Medicaid Services (CMS). The policy indicated staffing information during the recorded time period shall be made available to residents, family members, and the public within 24 hours of a written or verbal request.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175425	A. Building B. Wing	06/11/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Spring Hill Care and Rehab	251 E Wilson Avenue Spring Hill, KS 66083

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. The facility identified a census of 36 residents. The facility identified eight residents on Enhanced Barrier Precautions (EBP - infection control interventions designed to reduce transmission of resistant organisms that employ targeted gown and glove use during high contact care). Based on record reviews, observations, and interviews, the facility failed to store Resident (R) 33, R34, R6, and R1's respiratory equipment in a sanitary manner, and the facility further failed to transport linens in a sanitary manner. These deficient practices placed the residents at risk for infectious diseases. Included findings: - On 06/09/25 at 07:44 AM, a walkthrough of the facility was completed. On 06/09/25 at 07:57 AM, R33 laid on her right side in her bed. R33's CPAP mask was draped over the CPAP machine without a clean barrier and sanitary container. On 06/09/25 at 07:59 AM, R34 laid on his back on his bed. R34's CPAP mask laid on the floor on the right side of his bed. R34's CPAP machine without a clean barrier and sanitary container. On 06/09/25 at 08:02 AM, R6's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask hung from a thumb tack on her message board. R6's nebulizer mask was not stored in a sanitary manner. On 06/09/25 at 08:04 AM, R1's nasal cannula laid draped over her wheelchair. R1's nasal cannula was not contained in a sanitary manner. On 06/09/25 at 08:10 AM, laundry staff pushed a covered linen cart down the [NAME] Hall with bath blankets on top of the cart. The bath blankets were not stored in a sanitary manner. On 06/11/25 at 11:35 AM, Licensed Nurse (LN) G stated CPAP mask should be cleaned, air-dried, and placed in a plastic bag. LN G stated R33 used a CPAP. LN G stated linens should be transported in a cover cart. On 06/11/25 at 11:53 AM, Certified Nurse's Aide (CNA) M stated the CPAP mask should be placed in a drawer. She stated the nurse on duty usually took care of the respiratory equipment. CNA M stated she was unsure how linens should be transported. On 06/11/25 at 2:05 PM, Administrative Nurse D stated it was all nursing staff's duty to ensure all respiratory equipment was placed in a bag in a sanitary manner. Administrative Nurse D stated linens should be covered when transported in the halls. The facility did not provide a respiratory equipment storage policy. The facility's Handling of Clean Linen and Linen Distribution policy dated 10/24 documented clean laundry and bedding shall be handled in a manner that prevents gross microbial contamination of the air and person handling the linen.