STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility reported a census of 29 residents and one kitchen. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and preparation to prevent the spread of food borne illness to the residents of the facility. - Initial tour of the kitchen on 12/28/25 at 10:40 AM, revealed the following areas of concerns:There was an area on the floor at the entry to the kitchen from the dining area, approximately six inches long and one inch wide, that was missing tiles.There were multiple areas of the ceiling, including one area above the hand washing sink, that had flaking paint.There were three flies in the kitchen and an open tub of butter sitting on the counter next to an open bag of biscuits.There were various food waste items on the floor.In the food storage pantry, there was a package of spaghetti that was open with no date on the package.There was scattered flour on top of a flour container, the floor and on several shelves of a transport cart.The spice drawer had 16 open spice containers that were not dated. An opened smoked paprika container was expired with an expiration date of 11/14/25. There was a whole thyme container with a best by date of 02/12/24, and there was a pumpkin spice container with a best by date of 08/14/25. During an observation and interview on 12/29/25 at 09:20 AM, with Dietary CC, there was an open cinnamon container on the counter with no dating and she stated that the date was 11/11, with only the number 11 visible. Dietary CC stated that each cook was responsible for dating opened food items and throwing out the expired items. Dietary CC also stated that the night cook on 12/28/25 went through the spice drawer and dated the spices container and threw out the expired spice containers. Observed on 12/29/25 from 10:30 AM to 11:30 AM, the heating table temperatures, that were holding foods to be served to residents, were not temperature checked or recorded. The rice was temperature checked before it was pureed, but was not temperature checked any time after that, and no food was temperature checked before it was served. Observed on 12/29/25 at 10:55 AM, Dietary DD chopped lettuce and then bent over and coughed into the bottom of her shirt as she was holding the shirt with her gloved hand. Immediately after coughing into her shirt, she returned to her task of chopping the lettuce without performing hand hygiene or changing her gloves. Observed on 12/29/25 at 11:25 AM, Dietary DD used the knife that she was chopping chicken to open the plastic overwrap on a bottle of barbeque sauce and then returned to chopping chicken without washing or changing knives. Observed on 12/29/25 at 12:04 PM, Dietary GG delivered a food sample tray the surveyors and the food temperatures were not checked upon plating of the food or upon delivery of the food. During an observation and interview on 12/29/25 at 12:13 PM, Dietary CC delivered a cheeseburger to Resident (R) 18 in his room; the cheeseburger was not assessed for temperature prior to being delivered. R18 and his wife reported that the cheeseburger was cold. The food temperature logs, reviewed on 12/29/25 at 08:00 AM, revealed no meals served on 12/28/25 had temperatures recorded for the mechanical soft or pureed meals served. This was the same for 12/27, 12/26, 12/25. The main entree temperature for supper on 12/28/25 was 50 degrees, the vegetable temperature was 40 degrees, and the desert temperature was 80 degrees. During an interview on 12/28/25 at 12:05 PM, R2 reported that often the hot food is not hot. She reported that she sent her tray back on 12/27/25 and it was over 30 minutes before she received her food back. She also stated (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	that meats were often cold when she received her meals. R2 also stated that she sent her meats back and sometimes it came back hot and sometimes not. During an interview on 12/28/2025 2:35 PM, R7 reported that hot food was not always hot, often the meat was cold. During an interview on 12/29/25 at 08:10 AM, Dietary DD stated that pureed and mechanical soft diets were temperature checked and delivered meals were assessed for temperature just before being delivered to the residents. During an interview on 12/29/25 at 08:15 AM, Dietary CC stated that the steam table temperatures were checked throughout the meal serving time. She also stated that the cooks had always done just one temperature for the foods, they did not do another temperature after the foods were prepared for pureed or prepared as mechanical soft. Dietary CC also stated that the supper meal for 12/28/25 was tuna salad sandwiches, sliced tomatoes and the dessert was cherry cobbler. She then stated that the 50-degree temp for the tuna salad, which was served, concerned her. During an interview on 12/29/25 at 08:30, Dietary CC stated that the floor had been missing tiles since she started in June of 2025. During an interview on 12/29/25 at 11:30 AM, Dietary DD stated that she should have washed the knife or gotten a new one before she continued cutting chicken after she opened the condiment bottle. During an interview on 12/29/25 at 11:39 AM, Dietary DD stated that the storage temperature was 40 degrees Fahrenheit or below for any cold sandwich item, such as egg, tuna, or chicken salad. Dietary DD stated that the expectation was that if a cold entree such as tuna salad had temperature above the required temperature of 41 degrees, it should be thrown out and remade and the temperature verified before serving to the residents. During an interview on 12/2925 at 11:57 AM, Dietary BB stated that foods were to be temperature checked on the steam stable, and if there were resident complaints about cold food, a test tray was to have been done. Dietary BB also stated that pureed food should have been made, then reheated and temperature checked, then rechecked prior to sending out to the resident. She also stated that pureed temperatures should have been reordered, and that tuna salad should not be served at 50 degrees, without knowing how long it was at that temperature, and that it should have been chilled to the proper temperature before serving which should have been 41 degrees. During an interview on 12/29/25 at 12:37 PM, Dietary BB stated that a kitchen utensil that was being used for food preparation should not have been used to open a condiment bottle. She also stated that if a cook was preparing food and coughed or sneezed, that person should have changed gloves and washed hands before preparing food again. During an interview on 12/30/25 at 09:56 AM, Dietary GG stated that a person must perform proper hand hygiene after coughing or sneezing when preforming any task and returning to that task. He also stated that if a food preparation utensil that was being used for food preparation and then used on something else should be washed appropriately or a new one obtained before returning to food prep. During an interview on 12/30/25 at 10:00 AM, Dietary CC stated that a food preparation utensil used on food and then on another object could not then be used on the food again until it was properly washed because of cross contamination. She also stated that proper hand hygiene should be performed, and new gloves donned after touching clothes and/or coughing or sneezing. Dietary CC also stated that all temperatures, pureed, mechanical soft, and main entree should have been recorded, to include holding temperatures. During an interview on 12/30/25 at 12:10 PM, Dietary GG stated that the dietary aides and cooks were responsible for cleaning the kitchen and food pantry and that the kitchen was cleaned daily, and the pantry was cleaned weekly. During an interview on 12/30/25 at 12:15 PM, Dietary EE stated that the cook on duty was responsible for cleaning the kitchen daily and the food pantry weekly. During an interview on 12/30/25 at 12:20 PM, Dietary CC stated that the cook was responsible for cleaning the kitchen daily and that she was responsible for cleaning the food pantry every Tuesday or weekly. The facility policy Food Preparation and Service, dated 10/2025, defined food danger zone as temperatures above 41 degrees Fahrenheit and below 135 degrees F as this range would allow rapid growth of pathogenic microorganisms that could cause foodborne illness. This policy also documented that thermometers would be placed in hot and cold storage areas and checked for accuracy in accordance with accepted public health standards. The facility policy further documented that the (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	temperature of food held in steam tables would be monitored by food service staff. The facility policy Food Safety Requirements, dated 10/2025, documented that food services, or other designated staff, would maintain clean food storage areas at all times.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 0924 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Put firmly secured handrails on each side of hallways. The facility reported a census of 29 residents. Based on observation, interview and record review the facility failed to provide a safe and functional handrails in three of four hallways. Findings included:- Observed on 12/28/25 2:15 PM, there was a total of four loose handrails in the north resident hall. Observed on 12/29/25 at 09:53 AM, five handrails on the east resident hall were loose. There were three handrails on the south resident hall that were loose. Observed on 12/30/25 at 10:20 AM, administrative staff were checking the handrails throughout the building and marking those handrails that were loose for residents and staff to safely identify. During an interview on 12/30/25 at 09:44 AM, Administrative Nurse D stated that every employee was responsible and could submit work orders. Administrative Nurse D confirmed there were loose handrails on the resident halls. During an interview on 12/30/25 at 09:56 AM, Dietary GG stated every staff person was responsible for building maintenance and reporting damage. During an interview on 12/30/25 at 10:08 AM, Maintenance U stated that all staff were responsible for identifying and submitting maintenance work orders. Maintenance U also stated that handrails were checked every three to four months, and when walking down the hall. She further stated that she had not received any work orders that identified loose handrails. During an interview on 12/30/25 at 10:14 AM, Administrative Staff A stated that regular rounds were performed with an environmental checklist to maintain a safe and homelike environment. Administrative Staff A also stated that all staff were responsible for identifying any maintenance issues and submitting work orders.The facility policy Work Orders, Maintenance, dated 10/2025, documented that maintenance work orders should be completed in order to establish a priority of maintenance service.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility reported a census of 29 residents. The sample included 12 residents with four residents reviewed for hospitalization. Based on interview and record review, the facility failed to provide Resident (R) 4, R9, and R32 a written notification of transfer to the resident and/or his representative as soon as practicable and failed to send a copy of that notification to the ombudsman. The facility also failed to provide R4 or the responsible party with a bed hold. Findings included:1. R4's Electronic Medical Record (EMR) revealed a diagnosis of end-stage renal disease (ESRD- a terminal disease of the kidneys), cognitive communication deficit (an impairment in organization, sequencing, attention, memory, planning, problem-solving, and safety awareness), and dependance on dialysis (a procedure where impurities or wastes are removed from the blood).R4's Nursing Progress Note dated 08/20/25 at 06:38 PM documented R4 was not to eat or drink in the morning, and was to have a shower with Hibiclense (a strong hospital-grade antiseptic cleanser).R4's Nursing Progress Note dated 08/21/25 at 03:40 PM documented R4 was admitted to the hospital for observation due to having an allergic reaction to antibiotics given after surgery.R4's EMR lacked documentation of a signed bed hold or a written notification to the resident and/or her representative, which explained the reason for the transfer to the hospital. 2. R9's EMR revealed a diagnosis of hydronephrosis (swelling of the kidneys) with renal and ureteral calculous obstruction (kidney stones causing obstruction) and acute (a condition characterized by a relatively sudden onset of symptoms that are usually severe) kidney failure.R9's Social Services Note dated 12/05/25 at 09:56 AM documented R9 was transported to the hospital for a surgical procedure. The bed hold was signed.R9's EMR lacked documentation of a written notification to the resident and/or her representative, which explained the reason for the transfer to the hospital. 3.R32's EMR revealed a diagnosis of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid).R32's Nursing Progress Note dated 10/22/25 at 11:50 AM documented R32 was transported to the hospital for a cough with an oxygen level of 85 percent (%). Oxygen applied. R32 had weakness and was unable to swallow.R32's EMR lacked documentation of written notification to the resident and/or her representative, which explained the reason for the transfer to the hospital. On 12/29/25 at 10:49 AM, Social Services X stated that she was the person who goes over the bed hold with the resident and/or the resident's representative. Social Services X said she was unaware of the regulation to notify the resident in writing and notify the ombudsman of transfers. On 12/29/25 at 1:46 PM, Administrative Staff A stated the bed hold should be completed and signed when a person was transferred out of the facility. Administrative Staff A said she was unaware of the regulation to notify the resident's representative in writing of a discharge or transfer and confirmed the facility had not been notifying the ombudsman. The facility's F 628 Transfer and/or Discharge, Including Against Medical Advise (AMA), Discharge Notification (old 622, F623) policy dated 10/2025 documented the resident and/or representative will be provided a notice in writing with the reason for the transfer, effective date of the transfer, location to where the resident is being discharged /transferred, appeal rights, name, address, and telephone number of the ombudsman and the stated health department agency that has been designated to handle appeals of transfers and discharges.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 29 residents; there were 12 residents sampled, which included two residents selected for closed record review. Based on observation, interview, and record review the facility failed to ensure nursing documentation in Resident (R) 10's health record met the professional standards of care when staff repeatedly documented application and removal of compression stockings even when they were not applied, inaccurately representing the provision of treatments. Findings included:- R10's Electronic Medical Record (EMR) documented diagnosis of rhabdomyolysis (breakdown of damaged skeletal tissue), unspecified atrial fibrillation (rapid, irregular heartbeat), hypothyroidism (a condition characterized by decreased activity of the thyroid gland), and edema (swelling resulting from an excessive accumulation of fluid in the body tissues). R10's admission Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of nine, which indicated some cognitive impairment. The assessment documented R10 required supervision or touching assistance for upper body dressing and all footwear, to include socks. R10 required partial to moderate staff assistance for lower body dressing, The Activities of Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented that R27 required ADL assistance for self-care or mobility activities. R10's Quarterly MDS, dated 10/10/25, documented a BIMS score of 12, indicating moderate cognitive impairment. The assessment documented R10 required set-up or clean-up assistance for upper and lower body dressing, and footwear. R10's Care Plan recorded an intervention dated 06/02/25 that directed staff to encourage R10 to have her legs elevated when seated and to have thrombo-embolic-deterrent hose (TED hose - specialized compression stockings designed to help manage swelling of the feet/legs) on in the morning and removed at bedtime. R10's Orders tab revealed a physician order, dated 09/30/25, that documented R10 was to have compression hose on in the morning and off at bedtime for lower extremity swelling. R10's December 2025 Medication Administration Record/ Treatment Administration Record (MAR/TAR) reviewed from 12/01/25 through 12/30/25 had no documentation of application or removal of the compression stockings for 12/25/25. On 12/28/25, the MAR/TAR was documented R10's compression stockings had been applied at 06:00 AM and removed at 07:00 PM, and on 12/29.25, they were documented as on at 06:00 AM. Observed on 12/28/25 at 03:06 PM, R10's feet and ankles had swelling. She was not wearing compression stockings. Observed on 12/29/25 at 10:10 AM, R10 ambulated in the hall with her walker. Her feet and ankles appeared swollen, and she was not wearing compression stockings. During an interview on 12/29/25 at 10:35 AM, Certified Nurse Aide (CNA) M stated that CNAs and the nurse would double-check that treatments were performed. She also stated that if a resident refused a treatment, even compression stockings, CNA staff notified the nurse. CNA M also stated that the CNAs would report any observed swelling to the nurse. During an interview on 12/29/25 at 10:42 AM, Licensed Nurse (LN) G stated that the CNAs put on the compression stockings, and the nurse verified it was done; this was then recorded on the MAR/TAR. LN G also stated that the CNA would report refusal, and the refusal would then be charted on the MAR/TAR. She further confirmed that R10 was supposed to wear compression stockings daily and further confirmed that R10 was not wearing them currently. LN G further stated that R10 was independent with dressing and would put her compression stockings on herself, but would sometimes forget. LN G also stated that the MAR/TAR was charted in the morning, and she had assumed that R10 had put them on this AM, and she had not confirmed it before charting the stockings as on. During an interview on 12/29/25 at 11:04 AM, Administrative Nurse D stated that before charting any treatment, it was expected that the nurse would verify the treatment was performed before charting that it was completed or done. Administrative Nurse D also stated that if a resident was independent and would put her compression stockings on themselves, then it was expected that staff would verify that they were on. She further stated that if the resident did not want to wear compression stockings, (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	then it would be charted as a refusal, and if this was consistent, then the provider would be notified, and a discussion would be had about possibly removing the order for compression stockings, and the care plan would be updated to reflect the change. The facility policy Documentation Guidelines, dated 05/2025, documented those services provided to the resident, or any changes in the resident's medical or mental condition, should be documented in the resident's medical record.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175434	A. Building B. Wing	12/30/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Oswego Operator, LLC	1104 Ohio Street Oswego, KS 67356

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 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 29 residents. Based on interview and record review, the facility failed to electronically submit complete and accurate staffing information to the Federal regulatory agency through Payroll-Based Journaling (PBJ) when the facility failed to accurately submit hourly staffing data for all nursing personnel for weekends. Findings included:- The PBJ Staffing Data Report for Fiscal Year (FY) for Quarter 3 - 2025 (April 1 - June 30), indicated the facility had excessively low weekend staffing. On 12/30/25 at 09:28 AM, Administrative Staff A reported payroll data and scheduling data reflected the facility had the same coverage on weekends, if not more than every other day. On 12/30/25 at 10:28 AM, Consultant II stated that all registered nurses except the director of nursing were reported under the same category; therefore, the administrative nurses who work during the week were reported under the same category as licensed nurses who worked the floor. Consultant II stated that is why it appeared they had fewer staff on the weekend when the administrative staff were not working. The facility provided the Centers for Medicare and Medicaid Services Electronic Staffing Data Submission Payroll-Based Journal Long-Term Care Facility Policy Manual version 2.7 dated June 2025, documented the direct care staffing and census data will be collected quarterly and is required to be timely and accurate.