STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175435	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Holton	1121 W 7th Street Holton, KS 66436

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 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with two residents sampled for reasonable accommodations of resident needs and preferences. Based on observation, record review, and interview, the facility failed to ensure Resident (R) 22's call light was within her reach and further failed to ensure R6 was not pushed by staff without foot pedals. This deficient practice left R22 vulnerable for unmet care needs due to the inability to call for staff assistance and the possibility of falls and placed R6 at risk for preventable injury and avoidable accidents.Findings included:- R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), 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), and emphysema (long-term, progressive disease of the lungs characterized by shortness of breath). The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented R22 needed supervision/touching assistance from staff for eating, partial/moderated assistance for oral care, and was dependent on staff for toileting, bathing, dressing, and personal cares.The Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 05/09/25 documented staff were to continue to provide and assist with activities of daily living (ADL). The CAA for R22 documented the facility would continue to monitor and update R22's plan of care as needed. R22's Care Plan dated 06/24/25 documented R22 was at risk for falls due to confusion, balance problems, poor safety awareness, and dementia. R22's plan of care documented staff were to ensure the call light was within her reach and encourage the resident to use it for assistance as needed. The plan of care for R22 directed staff to ensure prompt response to all requests. On 08/25/25 at 07:11 AM, R22's call light was clipped to the privacy curtain at the bottom of her bed. R22 was unable to reach the call light. On 08/25/25 at 08:35 AM, Administrative Staff A pushed R6 into the dining room without foot pedals.On 08/26/25 at 07:05 AM, R22's call light was clipped to the privacy curtain at the bottom of R22's bed. R22 was unable to reach the call light. On 08/26/25 at 12:42 PM, Certified Medication Aide (CMA) R stated the residents' call lights should always be placed within the residents' reach. She stated if a resident was being pushed by staff, the resident should have foot pedals on her wheelchair. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated the call light should never be clipped to the privacy curtain; the call light should always be placed where the resident could reach the call light. LN I stated when a resident was pushed by a staff member, the staff member should apply the foot pedals. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the call lights should always be placed within the residents' reach. She stated that staff should apply the foot pedals when pushing a resident in a wheelchair. The facility did not provide an accommodation of needs policy.

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
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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 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. The facility identified a census of 34 residents. The sample included 12 residents, with three reviewed for Medicare Liability Notices. Based on the record review and interview, the facility failed to provide the cost for continued services information on the Advanced Beneficiary Notice (ABN Centers for Medicare and Medicaid Services (CMS) form 10055) for skilled services for Resident (R) 9. This placed the resident at risk for uninformed care decisions.Findings included:- Review of R9's ABN lacked documentation regarding the cost for continued skilled services ending on 7/24/25.On 08/26/25 at 01:27 PM, Administrative Nurse D stated that the beneficiary notice should have the cost on it to notify the residents.The facility's Advance Beneficiary Notices policy dated 11/05/24 documented the facility was to ensure timely notices regarding Medicare eligibility and coverage provided. The policy documented the facility would inform Medicare beneficiaries of his or her potential liability for payment.

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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 0584 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to a safe, clean, comfortable and homelike environment, including but not limited to receiving treatment and supports for daily living safely. The facility identified a census of 34 residents. The sample included 12 residents. Based on observations and interviews, the facility failed to provide a clean, home-like environment for the residents who resided in the facility.Findings included:- On 08/24/25 at 07:18 AM, a walk-through of the facility revealed a wheelchair, a Hoyer (total body mechanical lift), and two commodes placed on the back of hall 100. On 08/24/25 at 07:30 AM, in Resident (R) 22's room, behind her bed, was an approximately six-inch square hole in the wall. On 08/24/25 through 08/26/25, flies were in the dining room, in the kitchen, and on the nurse's desk. On 08/26/25 at 02:30 PM, Licensed Nurse (LN) I stated that staff filled out a work order for repairs or notified the maintenance department. LN I stated the equipment was moved from the hallways when residents were out of their beds. LN I stated there were a lot of flies, she stated the flies come in when residents in wheelchairs go outside to smoke and hold the patio door open. She stated that most of the residents have fly swatters. On 08/26/25 at 04:02 PM, Administrative Nurse D stated maintenance made rounds on a regular basis to check for repairs. Administrative Nurse D stated she was unaware of the equipment in the hallways, and commodes should not be left in the hall. She stated maintenance should be taking care of the flies; she was unaware that the flies were a problem. The facility's Safe Homelike Environment policy dated 06/05/24 documented the purpose of the policy was in accordance with the residents' rights and the facility would provide a safe, clean, comfortable, and homelike environment, allowing the resident to use their personal belongings to the extent possible. This would ensure that the resident can receive care services safely and the physical layout of the facility maximized the resident's independence and does not pose a safety risk.

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with seven residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure the physician had clarified the indication for Resident (R) 14's psychotropic (alters mood or thought) medication. The facility failed to ensure that the physician had clarified R6's gradual dose reeducation (GDR) for R6's antipsychotic (a class of medications used to treat major mental conditions that caused a break from reality) medication, R2's as-needed (PRN) Lorazepam (antianxiety medication(a class of medications that calm and relax people)), and R9's PRN Ativan (antianxiety medication) had a 14-day stop date. The facility further failed to ensure that the physician ordered monitoring related to R24's antidepressant (a class of medications used to treat mood disorders). This deficient practice placed R14, R6, R2, R9, and R24 at risk for unnecessary medication use and physical complications. Findings included:- R14's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and heart failure. The “admission Minimum Data Set (MDS)” dated 09/25/24 documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R14 had received a diuretic (a medication to promote the formation and excretion of urine) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented that R14 had received diuretic medication and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. R14's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)” dated 10/03/24 documented R14 had a self-care deficit and required staff assistance with most of his activities of daily living. R14's “Care Plan,” dated 10/07/24, documented nursing staff would administer medications as ordered by the physician. The plan of care documented nursing staff would monitor and document any side effects and effectiveness. R14‘s EMR under the “Orders” tab revealed the following physician orders: Mirtazapine (antidepressant) oral tablet 15 milligram (mg), give one tablet by mouth at bedtime for health maintenance, dated 07/08/25. On 08/24/25 at 09:03 AM, R14 laid on his bed with the head of his bed elevated as he watched TV. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated that she would clarify a physician order if there was a diagnosis that had an unusual indication for antidepressant medication. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she expected the charge nurse to clarify the order, if there was an off-label 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 - Some	The facility’s “Transcription of Orders/Following Physician Orders” policy, last revised 05/18/24, documented upon receiving a physician’s order via telephone, fax, written order, verbal order, transcribed order, or other, it would be documented in the residents’ electronic medical records in the orders section. Clarification of the Physician's Orders would be obtained if the order was either unclear or the nurse was uncomfortable with the implementation of the Physician's Orders. - R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), dysphagia (swallowing difficulty), Parkinson’s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). The “Annual Minimum Data Set (MDS)” dated 08/09/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R6 had received antipsychotic medication and antidepressant medication (a class of medications used to treat mood disorders). The MDS lacked documentation a GDR had been attempted, or the physician had documented that a GDR was contraindicated for R6. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R6 had received antipsychotic medication, antidepressant medication, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) medication. The MDS lacked documentation a GDR had been attempted, or the physician had documented a GDR was contraindicated for R6. R6's Psychotropic Drug Use Care Area Assessment (CAA)” dated 08/19/25 documented she had potential complications with the psychotropic medication she received. R6's “Care Plan,” dated 05/08/24, documented the facility would consult with the pharmacist and physician to consider a dose reduction when clinically appropriate. R6‘s EMR under the “Orders” tab revealed the following physician orders: Seroquel (antipsychotic) oral tablet (quetiapine fumarate- antipsychotic), give 50mg by mouth one time a day related to unspecified mood affective disorder, dated 02/22/24. Quetiapine fumarate oral tablet (Seroquel) 100 milligram (mg), give one tablet by mouth at bedtime for schizoaffective disorder, dated 10/10/24. Review of the “Monthly Medication Review” (MMR) provided by the facility from April 2025 through July 2025 lacked the physician's response to the Consulting Pharmacist (CP) recommendation for a GDR on 04/08/25 and 06/10/25 for R6’s psychotropic medications. The facility was unable to provide a physician's response upon request. The facility was also unable to provide MMRs from August 2024 through March 2025 upon request. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/25/25 at 07:53 AM, R6 wheeled her wheelchair from her room to the dining room without difficulty. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated she did not address the MMRs. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she expected the director of nursing to ensure the physician reviewed and addressed the CP recommendations and retain the MMRs once the physician had reviewed them. The facility’s “Gradual Dose Reduction of Psychotropic Drugs” policy, last revised 05/14/24, documented that residents who use psychotropic drugs received gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. - R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), hyperlipidemia (condition of elevated blood lipid levels), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acquired absence of left leg below the knee, schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual 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 R2 was dependent on staff for toileting, bathing, and dressing, and needed supervision or touching assistance from staff with eating. The MDS documented R2 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and an antianxiety (a class of medications that calm and relax people) medication during the observation period. R2's The Psychotropic Use Care Area Assessment (CAA) dated 06/30/25 lacked analysis. R2’s “Care Plan” dated 09/24/24 documented R2 had an activities of daily living (ADL) self-care performance deficit with potential for decline related to dementia (a progressive mental disorder characterized by failing memory and confusion), impaired balance, limited mobility, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R2's EMR under Orders documented the following physician's order: Lorazepam (anxiety medication) oral tablet, give 1.0 milligrams (mg) by mouth every two hours as needed for anxiety, dated 07/14/25. R2’s Lorazepam order lacked a 14-day stop date. On 08/24/25 at 08:35 AM, R2 sat in the dining room in her Broda chair (specialized wheelchair with the ability to tilt and recline). On 08/25/25 at 08:50 AM, R2 sat in her Broda chair in the dining room. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/25 at 12:55 AM, Licensed Nurse (LN) I stated she did not know there needed to be a 14-day stop date on PRN medication. She stated the director of nursing put in the orders for residents. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the director of nursing was putting in the orders and checking the pharmacy reviews. She stated she knew there needed to be a 14-day stop date. Administrative Nurse D stated if the director of nursing did not follow through with the pharmacy reviews, it was ultimately her responsibility to ensure they were all done. The facility’s “Transcription of Orders/Following Physician Orders” policy, last revised 05/18/24, documented upon receiving a physician’s order via telephone, fax, written order, verbal order, transcribed order, or other, it would be documented in the residents’ electronic medical records in the orders section. Clarification of the physician's orders would be obtained if the order was either unclear or the nurse was uncomfortable with the implementation of the physician's orders. - R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of insomnia (inability to sleep), sleep apnea (a disorder of sleep characterized by periods without respirations), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), hyperlipidemia (condition of elevated blood lipid levels), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and liver cell carcinoma (cancer). The “Quarterly 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 R9 needed supervision/touching with eating, partial/moderate assistance from staff for oral care, and was dependent on staff for toileting and bathing. The MDS did not document an antianxiety (a class of medications that calm and relax people) medication during the observation period. R9’s Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 03/16/25 lacked analysis. R9's “Care Plan” dated 07/08/25 directed staff to give medication as ordered by the physician, document, and monitor effectiveness and side effects. R9's EMR under Orders documented the following physician's order: Ativan (anxiety medication) oral tablet, give 0.5 milligrams (mg) by mouth as needed for anxiety, dated 07/29/25. R9’s PRN Ativan order lacked a 14-day stop date. On 08/25/25 at 08:34 AM, R9 sat in her wheelchair at the dining room table. R9 was eating from a red plate with raised edges. On 08/26/25 at 12:55 AM, Licensed Nurse (LN) I stated she did not know there needed to be a 14-day stop date on medication. She stated the director of nursing put in the orders for residents. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/25 at 01:25 PM, Administrative Nurse D stated the director of nursing put in the orders and checked the pharmacy reviews. She stated she knew there needed to be a 14-day stop date. Administrative Nurse D stated that if the director of nursing did not follow through with the pharmacy reviews, it was ultimately her responsibility to ensure they were all done. The facility’s “Transcription of Orders/Following Physician Orders” policy, last revised 05/18/24, documented upon receiving a physician’s order via telephone, fax, written order, verbal order, transcribed order, or other, it would be documented in the residents’ electronic medical records in the orders section. Clarification of the physician's orders would be obtained if the order was either unclear or the nurse was uncomfortable with the implementation of the physician's orders. - R24's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of bradycardia (low heart rate, less than 60 beats per minute), dementia (a progressive mental disorder characterized by failing memory and confusion), Parkinson’s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and dysphagia (swallowing difficulty). The “Quarterly Minimum Data Set (MDS) dated [DATE] for R24 documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R24 needed supervision/touching with eating, and substantial to maximal assistance with bathing and toileting. The MDS did not indicate R24 received hospice care. The MDS documented R24 received an antianxiety (a class of medications that calm and relax people) and an antidepressant (a class of medications used to treat mood disorders) during the observation period. R24’s “Psychotropic Drug Use Care Area Assessment (CAA) dated 03/03/24 lacked analysis. R24's “Care Plan” dated 08/08/25 documented R24 had a terminal diagnosis of Parkinson’s disease. The plan of care documented R24 would be comfortable and feel supported in his prognosis. R24‘s EMR under the “Orders” tab revealed the following physician orders: Alprazolam (antianxiety medication) oral tablet 0.5 milligrams (mg) (Alprazolam), give 0.5 tablet by mouth one time a day for sundowners, dated 07/31/25. Venlafaxine (antidepressant medication) HCl ER oral capsule extended release 24 Hour 150 MG (Venlafaxine HCl) give 1 capsule by mouth one time a day for depression, start date-04/23/25 and discontinued date- 08/05/25. Venlafaxine HCl ER Oral Tablet Extended Release 24 Hour 75 MG (Venlafaxine HCl), give 1 tablet by mouth in the morning for depression, dated 08/06/25. A Review of R24’s “Treatment Administration Record” lacked documentation of monitoring of behaviors for anxiety and depression. On 08/25/25 at 08:26 AM, R24 was sitting in his wheelchair in the dining room. (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/25 at 10:27 AM, R24 was sitting with a group of residents. On 08/26/25 at 12:55 AM, Licensed Nurse (LN) I stated she did not know there needed to be monitoring for antidepressant medications. She stated the director of nursing put in the orders for residents. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the director of nursing was putting in the orders and checking the pharmacy reviews. Administrative Nurse D stated that if the director of nursing did not follow through with the pharmacy reviews, it was ultimately her responsibility to ensure they were all done. The facility’s “Transcription of Orders/Following Physician Orders” policy, last revised 05/18/24, documented upon receiving a physician’s order via telephone, fax, written order, verbal order, transcribed order, or other, it would be documented in the residents’ electronic medical records in the orders section. Clarification of the physician's orders would be obtained if the order was either unclear or the nurse was uncomfortable with the implementation of the physician's orders.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure each resident receives an accurate assessment. The facility identified a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to complete the Care Area Assessment (CAA- analysis of findings) related to a Minimum Data Set (MDS), within the required time frame, for Resident (R) 4, R19, R2, and R9 to address the underlying cause, risk factors, and other contributing factors to ensure the resident received care based on their individual needs. This deficient practice placed the residents at risk for unidentified care needs. Findings included:- Review of R4's Electronic Medical Record (EMR) under the MDS tab revealed an admission MDS dated 03/17/25. Review of the CAAs dated 03/26/25 identified the following care areas lacked analysis: Functional Abilities (Self-Care and Mobility), Nutritional Status, Falls, Urinary Incontinence and Indwelling Catheter, and Psychotropic Drug Use. Review of 19's EMR under the MDS tab revealed an admission MDS dated 02/02/25. Review of the CAAs dated 02/17/25 lacked analysis and had documented will continue to monitor (wctm) under the following care areas, Functional Abilities (Self-Care and Mobility), Urinary Incontinence and Indwelling Catheter , Dehydration/Fluid maintenance, Nutritional Status, Pressure Ulcer, Falls, and Psychotropic Drug Use. Review of R2's EMR under the MDS tab revealed a Significant Change MDS' dated 06/18/25. Review of the CAAs dated 06/26/25 lacked analysis and had documented wctm under the following care areas, Cognitive Loss/Dementia, Functional Abilities (Self-Care and Mobility), Urinary Incontinence and Indwelling Catheter, Psychosocial Well-Being, Mood State, Behavioral Symptoms, Activities, Falls, Nutritional Status, Pressure Ulcer, and Psychotropic Drug Use. Review R9's EMR under the MDS tab revealed an admission MDS dated 03/12/25. Review of the CAAs dated 03/26/25, the following care areas lacked analysis: Functional Abilities (Self-Care and Mobility), Nutritional Status, Urinary Incontinence and Indwelling Catheter, Communication, Delirium, Cognitive Loss/Dementia, and Pressure Ulcer. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the MDS was completed off-site by a regional staff member. Administrative Nurse D stated that all triggered CAAs should have a complete analysis with measurable goals to create the resident's person-centered care plan. Administrative Nurse D stated that wctm was not an analysis of the triggered care area. The facility's Care Assessment Summary and Individualized Care Plan policy, last revised 11/06/23, documented the MDS 3.0 with the Care Area Assessment Summaries as a much more user-friendly assessment tool that addressed the holistic person, including functional status, quality of life, and individual plan of care to address and meet the needs of the individual resident. Section V was to be completed by the entire interdisciplinary Team (formerly RAPs, now CAA's - Care Area Assessment). The most important aspect to remember in this section was that the MDS does not constitute a comprehensive assessment without the Care Area Assessment Summary being completed. The Care Area Assessment Summary drives the development of the individualized care plan. A Care Area Trigger (CAT) alerts the assessor that interventions must be in place to address the care concern in the plan of care for the individual resident. All Care Area Assessment Summary Triggers must be addressed in the individualized plan of care for the resident. This area provided guidance on how to focus on key issues that are identified during the comprehensive MDS assessment. This area directed the facility staff to evaluate triggered care areas.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175435	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Holton	1121 W 7th Street Holton, KS 66436

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. (continued on next page)

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with 12 residents reviewed for comprehensive care plans. Based on observation, record review, and interviews, the facility failed to develop a comprehensive care plan for Resident (R) 33 for chronic pain, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), activities of daily living (ADL), vision, bowel and bladder, activities, falls, psychosocial, dehydration, risk for pressure ulcers (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). This deficient practice placed R33 at risk for impaired care due to uncommunicated care needs. Findings included:- R33's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of chronic pain, muscle weakness, DM, respiratory failure, depression, and anxiety. The admission Minimum Data Set (MDS) dated 03/28/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R33 was dependent on staff assistance with bathing, transfers, toileting, and bed mobility. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R33 was dependent on staff assistance for bathing, transfers, bed mobility, and toileting. R33's Visual Function Care Area Assessment (CAA) dated 03/29/25 documented social services would follow up and schedule an eye appointment. R33's Functional Abilities (Self-Care and Mobility) CAA dated 03/29/25 documented staff would assist him with ADLs and update his plan of care. R33's Urinary Incontinence and Indwelling Catheter CAA dated 03/29/25 documented staff would assist him with peri-care and update his plan of care. R33's Psychosocial Well-Being CAA dated 03/29/25 documented will continue to monitor (wctm). R33's Activities CAA dated 03/29/25 documented that the activities department would follow up with him. R33's Falls CAA dated 03/29/25 documented wctm.R33's Dehydration/Fluid maintenance CAA dated 03/29/25 documented wctm. R33's Pressure Ulcer CAA dated 03/29/25 documented nursing would complete weekly skin assessment. R33's Psychotropic Drug Use CAA dated 03/29/25 documented no adverse effects noted during the look-back period. R33's Care Plan dated 04/24/25 documented he was at nutritional risk related to his diagnosis of obesity (excessive body fat). The plan of care dated 06/26/25 documented R33 had a diagnosis of chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing). The plan of care lacked direction for medication administration, risk of dehydration, risk of falls, risk of development of pressure ulcers, psychosocial well-being, ADLs, activities, vision difficulties, and bowel and bladder function. On 08/25/25 at 8:20 AM, R33 laid on his back on the bed. R33's head of bed was slightly elevated. On 08/26/25 at 12:40 PM, Certified Medication Aide (CMA) R stated everyone had access to the residents' plan of care or their Kardex (nursing tool that gives a brief overview of the care needs of each resident). CMA R stated the person-centered plan of care, or the Kardex, should have the resident's individualized care needs listed. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated all staff had access to the residents' care plan or their Kardex. LN I stated that the residents' individualized care interventions could be found in the Kardex. LN I stated she had access to modify a resident's plan of care, but would let the director of nursing know what needed to be added or changed. On 08/26/25 at 01:25 PM, Administrative Nurse D stated all nursing staff had access to the resident's care plan and Kardex. Administrative Nurse D stated the director of nursing was responsible for ensuring the resident's person-centered care plan was developed, updated, and current with the resident's care needs. The facility's Comprehensive Care Plan policy, last revised 10/31/24 documented it was the policy of this facility to develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment.

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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. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, and 12 residents were reviewed for care plan revision. Based on observation, record review, and interviews, the facility failed to revise Resident (R) 19's care plan to include the dialysis (a procedure where impurities or wastes are removed from the blood) provider, frequency of visits, and chair time at dialysis. These deficient practices placed R19 at risk for impaired care due to uncommunicated care needs related to dialysis. Findings included:- R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of end-stage renal disease (ESRD- a terminal disease of the kidneys), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dependent on dialysis, and hypertension (HTN- elevated blood pressure). The admission Minimum Data Set (MDS) dated 02/02/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS lacked documentation R19 had received dialysis during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14, which indicated intact cognition. The MDS lacked documentation that R19 had received dialysis during the observation period. R19's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 02/17/25 document will continue to monitor. R19's Care Plan, dated 01/29/25, documented the nursing staff would ensure lab work or her blood pressure was not obtained from the arm with the graft. The plan of care documented the nursing staff would monitor for dry skin and apply lotion as needed. The plan of care documented the nursing staff would monitor labs and report to the physician as needed. The plan of care documented the nursing staff would monitor, document, and/or notify the physician of any signs or symptoms of depression and consult with mental health as needed. The plan of care documented nursing staff would monitor, document, and report as needed any signs or symptoms of infection at her access site. The plan of care documented nursing staff would monitor, document, and report as needed any signs or symptoms of insufficiency. The plan of care documented the nursing staff would monitor, document, and report as needed any signs or symptoms of bleeding or infection. The plan of care documented nursing staff would monitor, document, and report as needed any new or worsening peripheral edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The plan of care documented nursing staff would work with R19 to relieve discomfort from side effects of the disease and treatment. The plan of care lacked the location of R19's access site and access site assessment frequency. The plan of care lacked the dialysis provider, their location, the frequency of visits, the days of the week, and the chair time. R19's EMR under the Orders tab lacked a physician order for dialysis and monitoring of the access site. On 08/25/25 at 01:53 PM, R19 laid on her bed. R19 had pulled the blanket over her head as she slept. On 08/26/25 at 12:40 PM, Certified Medication Aide (CMA) R stated everyone had access to the residents' plan of care or their Kardex (nursing tool that gives a brief overview of the care needs of each resident). CMA R stated the person-centered plan of care, or the Kardex, should have the residents' individualized care needs listed. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated all staff had access to the residents' care plan or their Kardex. LN I stated the residents' individualized care interventions can be found in the Kardex. LN I stated she had access to modify a resident's plan of care, but would let the director of nursing know what needed to be added or changed. On 08/26/25 at 01:25 PM, Administrative Nurse D stated all nursing staff had access to the resident's care plan and Kardex. Administrative Nurse D stated the director of nursing was responsible for ensuring the resident's person-centered care plan was developed, updated, and current with the resident's care needs. The facility's Comprehensive Care Plan policy, last revised 10/31/24, documented the facility would develop and implement a comprehensive person-centered care plan for each resident, consistent with resident rights, that included measurable objectives and time frames to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the resident's comprehensive assessment. The comprehensive care plan would be reviewed and revised by the interdisciplinary team after each comprehensive and quarterly MDS assessment.

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F 0676 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure residents do not lose the ability to perform activities of daily living unless there is a medical reason. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with two residents sampled for activities of daily living (ADL). Based on observations, interviews, and record review, the facility failed to ensure Resident (R) 9's plan of care reflected assistance and monitoring while eating. This defiant practice placed the resident at risk for decreased quality of life, isolation, and impaired dignity.Findings Included:- R9's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of insomnia (inability to sleep), sleep apnea (a disorder of sleep characterized by periods without respirations), hypertension (high blood pressure), major depressive disorder (major mood disorder that causes persistent feelings of sadness), hyperlipidemia (condition of elevated blood lipid levels), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), metabolic encephalopathy (a condition in which brain function is disturbed either temporarily or permanently due to different diseases or toxins in the body), and liver cell carcinoma (cancer).The Quarterly 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 R9 needed supervision/touching with eating, partial/moderate assistance from staff for oral care, and was dependent on staff for toileting and bathing.R9's Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 03/16/25 lacked analysis.R9's Care Plan dated 03/30/25 documented a potential nutritional problem related to chronic conditions and overweight. The plan of care documented R9 would maintain adequate nutritional status by maintaining weight and consuming at least 75 percent of meals daily. The plan of care for R9 documented staff would provide and serve her diet as ordered and monitor her meal intake daily. R9's plan of care lacked an indication of the level of assistance and monitoring R9 required while eating.On 08/25/25 at 08:34 AM, R9 sat in her wheelchair at the dining room table. R9 was eating from a red plate with raised edges. R9 was scraping from the side of the plate; she was unable to get the eggs out of the plate. R9 had no assistance in the dining room. There were no staff left in the dining room to help or monitor R9.On 08/26/25 at 12:42 PM, Certified Medication Aide (CMA) R stated staff would know how much assistance each resident needed by word of mouth. She stated the nurse would let the staff know if a resident required staff help. CMA R stated she was not able to see the resident's care plan, but could see the Kardex (a nursing tool that gives a brief overview of the care needs of each resident).On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated she was not sure how much assistance a resident needed should be on the care plan. She stated that usually the hospital would call and let the nurse know how much assistance a resident needed, and that information was given to the aides in the report.On 08/26/25 at 01:25 PM, Administrative Nurse D stated that the amount of assistance a resident needed with care should be on the care plan. She stated that all nursing staff can see the Kardex, and any important information having to do with the care of a resident should pop up on the Kardex.The facility's Comprehensive Care Plan policy dated10/31/24 documented it was the policy of the facility to develop and implement a comprehensive person-centered care plan for each resident to meet a resident's medical, nursing, and mental and psychosocial needs that were identified in the resident's comprehensive assessment.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with four residents reviewed for accidents. Based on observation, record review, and interviews, the facility failed to secure the facility's electrical panel, a razor, and cleaning chemicals in a safe, locked area, and out of reach of eight cognitively impaired, independently mobile residents. The facility also failed to assess R5 for smoking safety. This deficient practice placed the residents at risk for preventable accidents and injuries. Findings included:- During the initial tour of the facility on 08/24/25 at 07:10 AM revealed an unsecured closet with open, unlocked electrical panels. Licensed Nurse (LN) G stated he was not sure if the closet should be locked and would let the director of nursing know. On 08/24/25 at 07:09 AM, the 100-hall shower room door was swung open. Inside the shower room, there was a cabinet that had a padlock hanging open on the lock, with the key in it. Inside the cabinet was shampoo, skin barrier wipes, a razor, and total bath skin and hair cleanser that read “Keep out of reach of children.” On the seat in the shower, there was a shampoo bottle left out that read “Keep out of reach of children.” On 08/25/25 at 07:58 AM, the closet with the electrical panel remained unsecured. Housekeeper Staff V stated he was not sure if the closet should be secured because there was no handle on the back of the door. Housekeeper Staff V stated he would report the unsecured door to the head of the maintenance department. On 08/25/25 at 08:24 AM, Maintenance Director U stated he was not sure the door should be secured. Maintenance Director U stated the door should be locked because the electrical panel’s keys did not lock the panels. On 08/26/25 at 12:57 PM, Licensed Nurse (LN) I stated that after the showers were completed, the supplies should be locked up. On 08/26/25 at 01:27 PM, Administrative Nurse D stated that the cabinet should be locked. On 08/26/25 at 01:40 PM, Administrative Staff A stated the closet with the electrical panels should be secured to prevent injuries. The facility’s “Accidents and Supervision Policy,” last revised 05/18/24, documented the resident environment would remain as free of accident hazards as possible. Each resident would receive adequate supervision and assistive devices to prevent accidents. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	- R5's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hemiparesis/hemiplegia (weakness and paralysis on one side of the body), following a 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) affecting right dominant side, hypertension (high blood pressure), aphasia (condition with disordered or absent language function), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), dysphagia (swallowing difficulty), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). The “Quarterly Minimum Data Set” (MDS) dated [DATE] documented that the facility was unable to conduct a Brief Interview of Mental Status (BIMS) score. R5’s MDS documented R5 was rarely or never understood. The MDS documented R5 needed supervision/touching assistance for eating and oral hygiene, and partial/moderate assistance from staff with toileting and bathing. R5's Falls Care Area Assessment (CAA) dated 03/17/25 documented no falls during the look-back period and would continue to monitor. R5’s “Care Plan” dated 06/06/25 documented R5 did own self-directed activities throughout the facility and in her room. R5’s plan of care documented that she would do activities of choice, and smoking was her favorite activity. R5’s plan of care lacked direction for staff to know how much assistance R5 needed with smoking materials. R5’s EMR under “Assessments” lacked a smoking assessment. Upon request, the facility was unable to provide a current smoking assessment. The facility did provide a smoking assessment for R5 dated 03/23. On 08/24/25 at 01:38 AM, R5 was at the nurse’s desk asking to go outside to smoke. On 08/25/25 at 10:36 AM, R5 was at the nurse’s desk asking staff to go outside to smoke. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated that all assessments pop up on the EMR when the assessment was due. She stated when the assessment came up, the nurse on duty or the director of nursing would ensure each assessment was done promptly. LN I stated that the facility did a smoking assessment on each resident who admitted to the facility. On 08/26/25 at 01:25 PM, Administrative Nurse D stated all nursing staff were responsible for ensuring the smoking assessment was done for each resident quarterly or as needed. She stated that normally the smoking assessment would pop up on the EMR, and that would be how the nurses would know the assessment was due. The facility’s “Accident and Supervision Policy” dated 05/18/24 documented the resident environment would remain as free of accident hazards as possible. Each resident would receive adequate supervision and assistive devices to prevent accidents. This includes identifying hazards and risks. Evaluating and analyzing hazards and risks, and implementing interventions to reduce hazards and risks.

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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 34 residents. The sample included 12 residents, with one resident reviewed for respiratory care. Based on observation, record review, and interviews, the facility failed to ensure Resident (R) 22's nebulizer (a device that changes liquid medication into a mist easily inhaled into the lungs) mask was stored in a sanitary container. This placed R22 at an increased risk for respiratory infection and complications.Findings Included:- R22's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and emphysema (long-term, progressive disease of the lungs characterized by shortness of breath).The Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview of Mental Status (BIMS) score of eight, which indicated moderately impaired cognition. The MDS documented R22 needed supervision/touching assistance from staff for eating, partial/moderated assistance for oral care, and was dependent on staff for toileting, bathing, dressing, and personal care.The Functional Abilities (Self-Care Mobility) Care Area Assessment (CAA) dated 05/09/25 documented that staff were to continue to provide and assist with activities of daily living (ADL). The CAA for R22 documented the facility would continue to monitor and update R22's plan of care as needed.R22's Care Plan dated 11/07/24 documented R22 had a new diagnosis of emphysema with chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) related to x-ray results, wheezing, lung sound diminished, and a loose, non-productive cough. R22's plan of care documented R22 had difficulty breathing, and staff should rinse her nebulizer after each treatment and ensure the mask was dry.R22's EMR under the Orders tab revealed the following physician order:Ipratropium-Albuterol inhalation solution (medication inhaled to open airways) 0.5-2.5 give 3 milligrams (mg)per 3 milliliters (ml), nursing to give one vial orally two times a day for shortness of breath, dated 11/10/24.Change nebulizer tubing weekly on Sunday night shift. Label with date, time, and initials. Keep tubing in a plastic bag when not in use every night shift, dated 11/10/24.On 08/25/24 at 07:11 AM, R22 laid in her bed, and her nebulizer laid on the bedside table without a clean barrier or a sanitary container.On 08/26/24 at 12:42 PM, Certified Medication Aide (CMA) R stated that any respiratory equipment not in use should be placed in a bag.On 08/26/25 at 12:55 PM, Licensed Nurse (LN) G stated that all respiratory equipment after being washed and air dried should be placed in a plastic bag, with the resident's name and date.On 08/26/24 at 01:25 PM, Administrative Nurse D stated all respiratory equipment should be cleaned and placed in a clear bag.The facility's Oxygen Administration Policy dated 05/18/24 directed staff to keep the delivery devices covered in a plastic bag when in use.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with one resident reviewed for hemodialysis (a procedure using a machine to remove excess water, solutes, and toxins from the blood in people whose kidneys can no longer perform these functions naturally). Based on observation, record review, and interviews, the facility failed to monitor Resident (R) 19's access site for complications at least daily and document arteriovenous (AV- a surgically created connection between artery and a vein used for hemodialysis) fistula for thrill (palpable vibration) and bruit (an audible vascular sound associated with turbulent blood flow usually heard with stethoscope that may occasionally also be palpated as a thrill) every day. This deficient practice placed R19 at risk of adverse outcomes and physical complications related to dialysis. Findings included:- R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of end-stage renal disease (ESRD- a terminal disease of the kidneys), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dependent on dialysis, and hypertension (HTN- elevated blood pressure). The admission Minimum Data Set (MDS) dated 02/02/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS lacked documentation R19 had received dialysis during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 14, which indicated intact cognition. The MDS lacked documentation that R19 had received dialysis during the observation period. R19's Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) dated 02/17/25 documented will continue to monitor. R19's Care Plan, dated 01/29/25, documented the nursing staff would ensure lab work or her blood pressure was not obtained from the arm with the graft. The plan of care documented the nursing staff would monitor for dry skin and apply lotion as needed. The plan of care documented the nursing staff would monitor labs and report to the physician as needed. The plan of care documented the nursing staff would monitor, document, and/or notify the physician of any signs or symptoms of depression and consult with mental health as needed. The plan of care documented the nursing staff would monitor, document, and report as needed any signs or symptoms of infection at her access site. The plan of care documented the nursing staff would monitor, document, and report as needed any signs or symptoms of insufficiency. The plan of care documented the nursing staff would monitor, document, and report as needed any signs or symptoms of bleeding or infection. The plan of care documented the nursing staff would monitor, document, and report as needed any new or worsening peripheral edema (swelling resulting from an excessive accumulation of fluid in the body tissues). The plan of care documented the nursing staff would work with R19 to relieve discomfort from side effects of the disease and treatment. R19‘s EMR under the Orders tab lacked a physician order for dialysis and monitoring of the access site. On 08/25/25 at 01:53 PM, R19 laid on her bed. R19 had pulled the blanket over her head as she slept. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated she assessed R19's access site before and after dialysis. LN I stated the nursing staff would notify the nurse if R19 had a problem with her access site on the days she did not receive dialysis. LN I stated she documented her assessment of R19's access site on the dialysis communication sheet on the days R19 had dialysis. LN I stated she would add a physician order for R19 to receive dialysis and add to monitor R19's access site. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she expected R19 to have a physician's order to receive dialysis and to monitor her access site daily. The facility's Dialysis policy, last revised 03/18/22, documented the facility would ensure that residents who required dialysis received such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

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F 0699 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide care or services that was trauma informed and/or culturally competent. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with one resident reviewed for trauma informed care (treatment or care directed to prevent re-experiencing or reducing the effects of traumatic events). Based on observation, record review, and interviews, the facility failed to identify trauma-based triggers related to Resident (R) 4's post-traumatic stress disorder (PTSD- mental disorder characterized by an acute emotional response to a traumatic event or situation involving severe environmental stress) and failed to implement individualized interventions to prevent re-traumatization. These deficient practices placed R4 at risk for decreased psychosocial well-being and ineffective treatment. Findings included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of PTSD, panic disorder, impulse, major depressive disorder (major mood disorder that causes persistent feelings of sadness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). The admission Minimum Data Set (MDS) dated 03/17/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R4 had an active diagnosis of PTSD. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R4 had an active diagnosis of PTSD. R4's Psychotropic Drug Use Care Area Assessment (CAA) dated 03/26/25 lacked analysis. R4's Care Plan, dated 07/22/25, documented her favorite activity was smoking. The plan of care lacked direction for her PTSD. R4's EMR under the Assessment tab lacked a trauma-informed care assessment.On 08/25/25 at 08:45 AM, R4 sat in her wheelchair in her room next to the bed. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated the social services department completed the trauma-informed care assessment on the residents in the facility. LN I stated that a resident with a diagnosis of PTSD should have a care plan to prevent re-traumatization. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she would expect the care plan to be updated with the past trauma and personalized interventions for the resident to prevent re-traumatization. The facility's Trauma Informed Care Policy, last revised 05/14/24, documented it was the policy of this facility to provide care and services which, in addition to meeting professional standards, were delivered using approaches that were culturally competent, accounting for experiences and preferences, and addressed the needs of trauma survivors by minimizing triggers and/or re-traumatization.

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F 0725 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide enough nursing staff every day to meet the needs of every resident; and have a licensed nurse in charge on each shift. The facility identified a census of 34 residents. The sample included 12 residents. Based on interview and record review, the facility failed to ensure adequate staffing levels on the weekends to meet the needs of the residents. This placed the residents at risk for impaired mental and physical wellbeing.Findings included:- Review of the Centers for Medicare and Medicaid Services (CMS) Payroll-Based Journal (PBJ) for Fiscal Year (FY) 2024 Quarter 4 and FY 2025 Quarter 2 revealed the facility triggered for excessively low weekend staffing. On 08/26/25 at 01:40 PM, Administrative Staff A stated the facility had low weekend staffing during that identified time from the PBJ report. Administrative Staff A stated the facility had struggled with staffing during that period. The facility was unable to provide a policy related to low weekend staffing.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. The facility identified a census of 34 residents. The sample included 12 residents and two Certified Nurse Aides (CNA) reviewed for yearly performance evaluations and the associated in-service training. Based on record review and interview, the facility failed to ensure two of the two CNA staff reviewed had yearly performance evaluations completed. This placed the residents at risk for inadequate care. Findings included:- A review of the facility's staffing list revealed the following CNAs were employed with the facility for more than 12 months: CNA M, hired on 06/20/24, had no yearly performance evaluation upon request. CNA N, hired on 04/24/24, had no yearly performance evaluation upon request. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the director of nursing and she would be responsible for ensuring the yearly performance reviews had been completed annually for the direct care staff. The facility failed to provide a policy related to required yearly performance reviews.

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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 34 residents. Based on record review, and interviews, the facility failed to maintain the posted daily nurse staffing data for the required 18 months. Findings included:- Review of the posted staffing sheets from 03/24/24 to 08/24/25 revealed the facility was unable to provide the posted staffing documentation for the requested period. On 08/26/25 at 01:40 PM, Administrative Staff A stated the management team had assigned the task of ensuring the daily posted nursing hours were posted daily and retained as required. Administrative Staff A stated, but ultimately, the director of nursing would be the responsible person to ensure the regulation was followed. The facility's Nurse Staffing Posting Information Policy, last revised on 06/26/24, documented it was the policy of the facility to make nurse staffing information readily available in a readable format to residents and visitors at any given time. Nursing schedules and posting information would be maintained in the Human Resources Department for review for a minimum of 18 months or as required by State law, whichever is greater.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with seven residents reviewed for unnecessary medications. Based on observation, record review, and interviews, the facility failed to ensure that the physician reviewed and addressed the Consultant Pharmacist (CP) recommendations for a gradual dose reduction (GDR) for Resident (R) 6's antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) medication and R14's psychotropic (alters mood or thought) medication indication. The facility also failed to ensure the CP identified and reported as needed diuretic (a medication to promote the formation and excretion of urine) medication lacked administration parameters. The facility further failed to ensure the CP identified and reported irregularities regarding the lack of dosing instructions for Voltaren (topical pain reliever medication) gel for R19. The facility failed to follow the CP's recommendation for R24's recommendation for monitoring of antidepressant medication (a class of medications used to treat mood disorders) for continued use and a 14-day stop date for R2's Lorazepam (an antianxiety medication). These deficient practices placed these residents at risk for unnecessary medication use, adverse side effects, and physical complications. Findings included:- R6's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), insomnia (inability to sleep), congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), dysphagia (swallowing difficulty), Parkinson’s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and schizoaffective (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought). The “Annual Minimum Data Set (MDS)” dated 08/09/24 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R6 had received antipsychotic medication and antidepressant medication (a class of medications used to treat mood disorders). The MDS lacked documentation a GDR had been attempted, or the physician had documented a GDR was contraindicated for R6. The Quarterly MDS dated [DATE] documented a BIMS score of 15, which indicated intact cognition. The MDS documented that R6 had received antipsychotic medication, antidepressant medication, and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) medication. The MDS lacked documentation a GDR had been attempted, or the physician had documented a GDR was contraindicated for R6. R6's Psychotropic Drug Use Care Area Assessment (CAA)” dated 08/19/25 documented she had the potential for complications with the psychotropic medication she received. R6's “Care Plan,” dated 05/08/24, documented the facility would consult with the pharmacist and physician to consider a dose reduction when clinically appropriate. R6‘s EMR under the “Orders” tab revealed the following physician orders: Seroquel (antipsychotic) oral tablet (quetiapine fumarate- antipsychotic), give 50 mg by mouth one time a day related to unspecified mood affective disorder, dated 02/22/24. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Quetiapine fumarate oral tablet (Seroquel) 100 milligram (mg), give one tablet by mouth at bedtime for schizoaffective disorder, dated 10/10/24. Review of the “Monthly Medication Review” (MMR) provided by the facility from April 2025 through July 2025 lacked a physician response to the CP recommendation for GDR on 04/08/25 and 06/10/25 for R6’s psychotropic medications. The facility was unable to provide a physician's response upon request. The facility was also unable to provide MMRs from August 2024 through March 2025 upon request. On 08/25/25 at 07:53 AM, R6 wheeled her wheelchair from her room to the dining room without difficulty. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated she did not address the MMRs. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she expected the CP to identify and recommend a GDR when needed for psychotropic medications. Administrative Nurse D stated she expected the director of nursing to ensure the physician reviewed and addressed the CP recommendations and retained the MMRs once the physician had reviewed them. The facility’s “Gradual Dose Reduction of Psychotropic Drugs” policy, last revised 05/14/24, documented residents who use psychotropic drugs received gradual dose reductions and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. - R14's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of atrial fibrillation (rapid, irregular heartbeat), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and heart failure. The “admission Minimum Data Set (MDS)” dated 09/25/24 documented a Brief Interview of Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R14 had received a diuretic (a medication to promote the formation and excretion of urine) during the observation period. The Quarterly MDS dated [DATE] documented a BIMS score of 12, which indicated moderately impaired cognition. The MDS documented that R14 had received diuretic medication and antidepressant (a class of medications used to treat mood disorders) medication during the observation period. R14's Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA)” dated 10/03/24 documented he had a self-care deficit and required staff assistance with most of his activities of daily living. R14's “Care Plan,” dated 10/07/24, documented nursing staff would administer medications as ordered by the physician. The plan of care documented nursing staff would monitor and document any side effects and effectiveness. R14‘s EMR under the “Orders” tab revealed the following physician orders: (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Mirtazapine (antidepressant) oral tablet 15 milligram (mg), give one tablet by mouth at bedtime for health maintenance, dated 07/08/25. Torsemide (diuretic) oral tablet 10 mg, give half tablet (5 mg) by mouth twice a day as needed for edema or weight gain, dated 07/08/25. Torsemide oral tablet, give 5 mg by mouth two times a day, related to heart failure and atrial fibrillation, dated 07/08/25. The Torsemide orders lacked parameters for when to give the diuretic medication. Review of the “Monthly Medication Review” (MMR) provided by the facility from April 2025 through July 2025 lacked evidence of notification for a lack of administration parameters for as-needed diuretic medication. The CP had identified and requested a clarification for the indication for antidepressant medication. The facility was unable to provide MMRs from August 2024 through March 2025 upon request. On 08/24/25 at 09:03 AM, R14 laid on his bed with the head of his bed elevated as he watched TV. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated that there should be administration instructions on any order. LN I stated she would clarify any order that did not have administration parameters with the order. LN I stated she did not address the MMRs. LN I stated she had administered the as-needed diuretic at times per request of R14’s physician. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she expected the CP to identify the lack of administration parameters for as-needed diuretic medication. Administrative Nurse D stated she expected the charge nurse to clarify the order if it lacked the administration instructions. Administrative Nurse D stated she expected the CP to identify any irregularities. Administrative Nurse D stated the director of nursing was responsible for ensuring the MMRs were reviewed by the physician and addressed on a regular basis. The facility’s “Medication Regimen Review” policy, last revised 06/26/24, documented the drug regimen of each resident was to be reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. Medication Regimen Review (MRR), or Drug Regimen Review, was a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. - R19's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of end-stage renal disease (ESRD- a terminal disease of the kidneys), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), dependent on dialysis, and hypertension (HTN- elevated blood pressure). The “admission Minimum Data Set (MDS)” dated 02/02/25 documented a Brief Interview of Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS lacked documentation R19 had received dialysis during the observation period. The MDS documented R19 had received antiplatelet (medication that helps prevent blood clots from occurring) and anticoagulant (a class of medications used to prevent the blood from clotting) during the observation period. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The Quarterly MDS dated [DATE] documented a BIMS score of 14, which indicated intact cognition. The MDS lacked documentation that R19 had received dialysis during the observation period. The MDS documented R19 had received antiplatelet (medication that helps prevent blood clots from occurring) and anticoagulant (a class of medications used to prevent the blood from clotting) medication during the observation period. R19's Psychotropic Drug Use Care Area Assessment (CAA)” dated 02/17/25 documented will continue to monitor. R19's “Care Plan,” dated 02/15/25, documented nursing staff would educate R19 and her legal representative on the physician-ordered analgesics (medication to relieve pain) and/or anti-inflammatory (medication that relieves pain, redness, and swelling). R19‘s EMR under the “Orders” tab revealed the following physician orders: Voltaren gel (topical) to both thighs every six hours as needed for pain, dated 06/13/25. The order lacked dosing instructions. Review of the “Monthly Medication Review” (MMR) provided by the facility from April 2025 through July 2025 lacked evidence of notification for a lack of dosing instructions for the Voltaren gel. The facility was unable to provide MMRs from August 2024 through March 2025 upon request. On 08/25/25 at 01:53 PM, R19 laid on her bed. R19 had pulled the blanket over her head as she slept. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) I stated that there should be administration instructions on any order. LN I stated she would clarify the Voltaren topical gel for R19. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she expected the CP to identify the lack of dosing instructions for R19’s Voltaren topical gel. Administrative Nurse D stated she expected the charge nurse to clarify the order if it lacked administration instructions. The facility’s “Medication Regimen Review” policy, last revised 06/26/24, documented the drug regimen of each resident was to be reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. Medication Regimen Review (MRR), or Drug Regimen Review, was a thorough evaluation of the medication regimen of a resident, with the goal of promoting positive outcomes and minimizing adverse consequences and potential risks associated with medication. - R24's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of bradycardia (low heart rate, less than 60 beats per minute), dementia (a progressive mental disorder characterized by failing memory and confusion), Parkinson’s disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and dysphagia (swallowing difficulty). (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The “Quarterly Minimum Data Set (MDS) dated [DATE] for R24 documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R24 needed supervision or touching with eating, and substantial/maximal assistance with bathing and toileting. The MDS did not indicate R24 received hospice care. The MDS documented R24 received an antianxiety (a class of medications that calm and relax people) and an antidepressant (a class of medications used to treat mood disorders) during the observation period. R24’s “Psychotropic Drug Use Care Area Assessment (CAA) dated 03/03/24 lacked analysis. R24's “Care Plan” dated 08/08/25 documented R24 had a terminal diagnosis of Parkinson’s disease. The plan of care documented R24 would be comfortable and feel supported in his prognosis. The plan of care documented R24 had chosen a hospice provider. R24‘s EMR under the “Orders” tab revealed the following physician orders: Alprazolam (antianxiety medication) oral tablet 0.5 milligrams (mg) (Alprazolam), give 0.5 tablet by mouth one time a day for sundowners, dated 07/31/25. Venlafaxine (antidepressant medication) HCl ER Oral Capsule extended release 24 Hour 150 MG (Venlafaxine HCl) give 1 capsule by mouth one time a day for depression, start date- 04/23/2 and discontinue date- 08/05/25. Venlafaxine HCl ER Oral Tablet Extended Release 24 Hour 75 MG (Venlafaxine HCl), give 1 tablet by mouth in the morning for depression, dated 08/06/25. A review of R24’s “Monthly Medication Review” (MMR) from August 2024 through July 2025 revealed an MMR dated 06/10/25, directed staff to monitor the need for R24’s antidepressant medication. A review of R24’s “Treatment Administration Record” (TAR) lacked evidence or documentation of the monitoring of specific behaviors associated with each disorder daily. On 08/25/25 at 08:26 AM, R24 was sitting in his wheelchair in the dining room. On 08/26/25 at 10:27 AM, R24 was sitting with a group of residents. On 08/26/25 at 12:55 AM, Licensed Nurse (LN) I stated she did not know there needed to be monitoring for antidepressant medications. She stated the director of nursing put in the orders for residents. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the director of nursing was putting in the orders and checking the pharmacy reviews. Administrative Nurse D stated if the director of nursing did not follow through with the pharmacy reviews, it was ultimately her responsibility to ensure they were all done. (continued on next page)

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	The facility’s “Medication Regimen Review” policy, last revised 06/26/24, documented that the drug regimen of each resident was to be reviewed at least once a month by a licensed pharmacist and included a review of the resident's medical chart. Medication Regimen Review (MRR), or Drug Regimen Review, was a thorough evaluation of the medication regimen of a resident, to promote positive outcomes and minimize adverse consequences and potential risks associated with medication. - R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), hyperlipidemia (condition of elevated blood lipid levels), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acquired absence of left leg below the knee, schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). The Annual 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 R2 was dependent on staff for toileting, bathing, and dressing, and needed supervision or touching assistance from staff with eating. The MDS documented R2 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and an antianxiety (a class of medications that calm and relax people) medication during the observation period. R2's The Psychotropic Drug Use Care Area Assessment (CAA) dated 06/30/25 lacked analysis. R2’s “Care Plan” dated 09/24/24 documented R2 had an activities of daily living (ADL) self-care performance deficit with potential for decline related to dementia (a progressive mental disorder characterized by failing memory and confusion), impaired balance, limited mobility, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R2's EMR under Orders documented the following physician's order: Lorazepam (anxiety medication) oral tablet, give 1.0 milligrams (mg) by mouth every two hours as needed for anxiety, dated 07/14/25. The facility lacked documentation or evidence the CP recommendations were acknowledged and/or acted upon for R2’s lorazepam order for anxiety. On 08/24/25 at 08:35 AM, R2 sat in her room, in her Broda chair (specialized wheelchair with the ability to tilt and recline). On 08/25/25 at 08:50 AM, R45 sat in her Broda chair watching TV and visited appropriately. On 08/26/25 at 12:55 AM, Licensed Nurse (LN) I stated she did not know there needed to be a 14-day stop date on medication. She stated the director of nursing was putting in the orders for residents. (continued on next page)

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	175435	A. Building B. Wing	08/26/2025

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	On 08/26/25 at 01:25 PM, Administrative Nurse D stated the director of nursing was putting in the orders and checking the pharmacy reviews. She stated she knew there needed to be a 14-day stop date. Administrative Nurse D stated if the director of nursing did not follow through with the pharmacy reviews, it was ultimately her responsibility to ensure they were all done. The facility’s “Transcription of Orders/Following Physician Orders” policy, last revised 05/18/24, documented upon receiving a physician’s order via telephone, fax, written order, verbal order, transcribed order, or other, it would be documented in the residents’ electronic medical records in the orders section. Clarification of the physician's orders would be obtained if the order was either unclear or the nurse was uncomfortable with the implementation of the physician's orders.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, two medication carts, one Licensed Nurse (LN) medication cart, and one medication room. Based on observation, record review, and interview, the facility failed to store drugs and biologicals for the residents in the medication cart and the medication room that were labeled with opened on dates for the liquid vials and not expired oral medications. This deficient practice placed the residents at risk for an ineffective medication regimen.Findings included:- On [DATE] at 08:55 AM, during the review of the LN medication cart an Insulin Lispro (fast-acting insulin that lowers blood sugar in people with diabetes) lacked a date for when it was opened, and an Insulin Glargine (long-acting insulin for type 1 and type 2 diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin)) vial was dated [DATE]. LN G verified that there was no open date for the Insulin Lispro vial and that the Insulin Glargine vial had expired. LN G stated both vials should be destroyed.On [DATE] at 10:05 AM, during the medication cart review, the following medications were found to be expired:Resident (R) 2's Midodrine (used to treat low blood pressure) 5 milligram (mg) tablets given as needed (PRN), 60 tablets expired on [DATE].R30's meclizine (treats or prevents motion sickness and vertigo) 12.5 mg tablets given PRN, on two expired cards: [DATE] and [DATE]. R20's furosemide (a loop diuretic used to treat fluid retention and high blood pressure by increasing urine output) 20 mg tablets given PRN, 11 tablets, expired on [DATE].R23's Cyclobenzaprine (a muscle relaxant used to relieve muscle spasms) 10 mg tablets, 16 tablets given PRN, expired [DATE].On [DATE] at 10:09 AM, Certified Medication Aide (CMA) R confirmed the medications had expired and removed the cards from the medication cart.On [DATE] at 10:18 AM, during the medication room review, 19 over-the-counter medications were found to be expired in the supply shelves; CMA R confirmed the expired over-the-counter medications. In the refrigerator in the medication room, there were two opened Tuberculous (TB- a serious lung infection caused by bacteria) vials and one opened Insulin Lispro vial; all three vials lacked a date for when the vials were opened or when the vials would expire. CMA R verified the vials lacked any dates.On [DATE] at 01:27 PM, Administrative Nurse D stated that the medications that were expired should be removed from the medication cart and medication room, and all vials should be dated.The facility's Medication Storage Policy dated [DATE] documented the facility was to ensure all medications housed on the premises would be stored in the medication rooms according to the manufacturer's recommendations. The policy documented that the pharmacist would routinely inspect for discontinued, outdated, defective, or deteriorated medications.

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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 34 residents. The facility had one kitchen and a dining kitchenette. Based on interviews and record review, the facility failed to provide the services of a full-time certified dietary manager for the 34 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 08/24/25 at 07:25 AM, Dietary Staff BB stated he had been with the facility for a few months. He was not registered for the dietary program, but he had been looking at how to get into the dietary managers' classes. Dietary Staff BB stated the Registered Dietitian (RD) came to the facility monthly. On 08/24/25 at 10:25 AM, Administrative Staff A stated the facility did not have a certified dietary manager, and the dietary manager was not in the dietary managers' class at this time. She stated the RD came to the facility monthly. The facility did not provide a policy for the dietary manager's position.

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F 0802 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide sufficient support personnel to safely and effectively carry out the functions of the food and nutrition service. The facility identified a census of 34 residents. The facility had one main kitchen and a dining kitchenette. Based on observation, record review, and interview, the facility failed to ensure that the facility had sufficient staff with the appropriate competencies and skill sets to carry out the functions of the Food and Nutrition Services. This deficient practice resulted in poor sanitary conditions in the kitchen and placed the residents at risk of potentially impaired nutrition.Findings included:- On 08/25/25 at 11:40 AM, Dietary Staff BB was the only dietary staff in the kitchen. Dietary Staff BB stated that he had two other staff members, but they both needed Mondays and Tuesdays off. Dietary Staff BB stated he did not have enough kitchen staff to keep the kitchen clean, cook food, and do dishes. He stated the facility had some applications, but the facility had not hired anyone yet.On 08/25/25 at 08:15 AM, Administrative Staff A stated she was aware there was not enough staff in the kitchen. She stated they did have applicants. Administrative Staff A stated that the dietary staffing was low, and she would try to get Dietary Staff BB some help in the kitchen.On 08/25/25 at 08:30 AM, approximately 10 residents sat at the dining room tables. R2 stated it was always after 08:30 AM before the breakfast trays were passed.On 08/25/25 at 08:32 AM, staff entered the dining room and began passing food trays out to residents in the dining room. The meal on the tray was scrambled eggs, bacon, and cereal. A review of the facility's posted meal service times listed the following times: Breakfast- 07:30 AM to 08:30 AM; Lunch- Noon to 01:00 PM; Dinner- 05:00 PM to 06:00 PM.The facility did not provide a policy for dietary staffing.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility identified a census of 34 residents. The facility had one kitchen and a dining area kitchenette. Based on observation, record review, and interviews, the facility failed to follow sanitary dietary standards related to dirty dishes and food storage. This deficient practice placed the residents at risk for food-borne illness.Findings included:- During the initial tour on 08/24/25 at 07:10 AM, observation revealed the following:The dietary manager was not wearing a hair net. The bowls and plates were not stored inverted. The steam table had dried food on the top, and dried food particles of tomatoes and a red substance had run down the front of the table. In the two-door stainless steel refrigerator, there was dried food on the outside of the refrigerator, and the handles were sticky and dirty. In the refrigerator, a plate with goulash and mixed vegetables was undated, an open Cool Whip container, an open sour cream container, and cucumbers were undated. A sliver bowl of cut-up lettuce was undated. On a single door white freezer, the handle had dark brown color on the handle, and on the outside of the freezer. The inside of the freezer had hamburger patties, French fries, and chicken strips open to air, all undated and no labels. On the floor, a sugar bin where two bags of sugar were open and undated; the bin had old, dried sugar and food particles at the bottom. On the lid of the bin was a dried brown substance. On the floor, the flour bin was a large bag of flour, the bin was undated, and a sticky, greasy substance was on the lid. In the dining area kitchenette, the ice machine had a dark brown substance along the spout where ice came out, and the drain had dark brown colored substance on the plastic grates. Under the kitchen cabinet was a two-gallon white bucket that was half full of a black substance. Around the white bucket were dead bugs. The brown refrigerator temperature log was dated 06/20/25. The top freezer of the refrigerator was full of frost, with ice cream and ice pops that were undated when opened. The refrigerator part had four ham sandwiches in a small steam table pan that were undated. Gallons of milk and juice that were unlabeled and undated. On 08/25/25 at 11:44 AM, the recheck of the kitchen in the double-door refrigerator revealed that salad dressings were unlabeled and undated. Dried eggs were on the steam table around the ham that was for lunch. On the plates and bowls were over 10-15 flies. On 08/24/25 at 07:25 AM, Dietary Staff BB stated all foods should be dated and labeled. He stated he did not know whether food in its original containers needed an open date. He stated he had been very short-staffed. Dietary Staff BB stated the steam table should be cleaned often and after each meal. He stated dishes should be inverted, or the covers should be on the plate and bowl hold containers. He stated he did not know sugar and flour should be dated; he stated the kitchen staff tried to clean the containers at least every six months. Dietary Staff BB stated he would get the food, and grime wiped off the front of the refrigerator and freezer. He stated the flies had been bad in the kitchen since the air conditioning system went out about five months ago. Dietary Staff BB stated he was unsure whose duty it was to clean the dining kitchenette. He stated he knew the refrigerator was the kitchen's duty, but did not know who should clean the bucket from under the sink. He stated the staff had gotten behind on taking temperatures in the dining area on the refrigerator, and the food on the top of the refrigerator, he thought, was the activity department's. Dietary Staff BB stated that the night snacks were the kitchen's duty. On 08/24/25 at 08:10 AM, Administrative Staff A stated the facility had been trying to get the dietary manager more staffing. She stated the facility had been talking to the dietary manager about keeping the kitchen clean. The facility's Sanitary Procedures policy, revised on 11/06/23, documented staff must wear a head covering with a hairnet. The facility's Dietary Equipment Operations policy dated 02/02/24 documented the dietary manager would record all cleaning and sanitation tasks for the dietary department. A cleaning schedule shall be posted with tasks designated to specific positions in the department. The policy stated all tasks shall be addressed as to the frequency of cleaning. The procedures to be used are listed in this Policies and Procedures Manual. General daily and weekly cleaning schedules may be used.

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

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with four residents reviewed for hospice (a type of health care that focuses on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life) services. Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice, was developed and available for Resident (R) 24 and R2. This placed the resident at risk for inappropriate end-of-life care. Findings included:- R24's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of bradycardia (low heart rate, less than 60 beats per minute), dementia (a progressive mental disorder characterized by failing memory and confusion), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), and dysphagia (swallowing difficulty). The Quarterly Minimum Data Set (MDS) dated [DATE] for R24 documented a Brief Interview of Mental Status (BIMS) score of five, which indicated severely impaired cognition. The MDS documented R24 needed supervision or touching assistance with eating, and substantial/maximal assistance with bathing and toileting. The MDS did not indicate R24 received hospice care. The admission MDS dated 03/13/25 did not indicate R24 received hospice services. R24's Cognitive Loss/Dementia Care Area Assessment (CAA) dated 03/03/24 lacked analysis. R24's Care Plan dated 08/08/25 documented R24 had a terminal diagnosis of Parkinson's disease. The plan of care documented R24 would be comfortable and feel supported in his prognosis. The plan of care documented R24 had chosen a hospice provider.The EMR under the Orders tab documented R24 was admitted to hospice on 08/06/25.A review of the hospice-provided communication binder revealed R24 was admitted to hospice services on 08/06/25. R24's last documented hospice visit was 08/20/25. On 08/25/25 at 08:26 AM, R24 was sitting in his wheelchair in the dining room. On 08/26/25 at 10:27 AM, R24 sat with a group of residents.On 08/26/25 at 12:42 PM, Certified Medication Aide (CMA) R stated she was unsure what hospice provided for the residents. She stated each resident on hospice had a binder, but she was unsure what information was included in the binder. CMA R stated it was by word of mouth that she would know who was on hospice, when the hospice staff would be coming, and what supplies the hospice provider provided. On 08/26/25 at 12:55 PM, Licensed Nurse (LN) G stated she was unsure what hospice provided. She stated she did not do the care plans. LN G stated she did not think what hospice provided would need to be on the facility's care plan. LN G stated all staff did not have access to each resident's care plan. She stated the Certified Nursing Aides (CNA) and CMAs have access to the Kardex (a nursing tool that gives a brief overview of the care needs of each resident). LN G was unsure if there was anything about hospice on the Kardex. She stated that when a resident was on hospice, the staff knew by word of mouth. On 08/26/25 at 01:25 PM, Administrative Nurse D said she knew the hospice providers had detailed care plans and staff would know specific services by those. She stated she thought everything hospice provided should be on the care plan, so staff know who to call and when the hospice staff are to be at the facility.The facility's Coordination of Hospice Services policy dated 05/18/24 documented when a resident chooses to receive hospice care and services, the facility would coordinate and provide care in cooperation with hospice staff to promote the resident's highest practicable physical, mental, and psychosocial well-being. The facility would communicate with hospice and identify, communicate, follow, and document all interventions put into place by hospice and the facility. The facility would maintain communication with hospice as it relates to the residents' plan of care services to ensure each entity was aware of their responsibilities. - R2's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of hypertension (high blood pressure), hyperlipidemia (condition of elevated blood lipid levels), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), acquired absence of left leg below the knee, schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), and major depressive disorder (major mood disorder that causes persistent feelings of sadness).The Annual 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 R2 was dependent on staff for toileting, bathing, and dressing, and needed supervision or touching assistance from staff with eating. The MDS documented R2 was

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. The facility identified a census of 34 residents. The facility identified six 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) 2 and R22's respiratory equipment in a sanitary manner. The facility additionally failed to supply the laundry room with a gown to sort dirty laundry and failed to transport laundry with the laundry being covered in a sanitary manner. The facility further failed to ensure it had trends and tracking for Legionella. These deficient practices placed the residents at risk for infectious diseases. Findings included:- On 08/24/25 at 07:17 AM, a walkthrough of the facility was completed. A canister with a nasal cannula sat inside R2's room; the nasal cannula was wrapped around the handle of the canister. The cannula was not stored in a sanitary manner. On 08/24/25 at 08:00 AM, a tour of the dirty laundry room revealed no gown to wear when sorting dirty laundry. Laundry Staff W stated she was unaware that the facility needed to wear a gown to sort dirty laundry. On 08/24/25 at 08:25 AM, Laundry Staff W pushed a clean laundry cart down the hall. The laundry cart had clothing and linens on top of the cart, uncovered and not stored in a sanitary manner. On 08/25/25 at 07:11 AM, R22 laid in her bed, and her nebulizer lay on the bedside table without a clean barrier or sanitary container. On 08/26/25 at 01:11 PM, upon request, the facility was unable to provide trend and tracking specific to the facility for the Legionella (Legionella is a bacterium which can cause pneumonia in vulnerable populations) monitoring. Administrative Staff A stated there had been a change in staffing, and she could not find any documentation for Legionella. She stated she did order a Legionella test kit. On 08/26/25 at 12:42 PM, Certified Medication Aide (CMA) R stated that any respiratory equipment not in use should be placed in a bag.On 08/26/25 at 12:55 PM, Licensed Nurse (LN) G stated that all respiratory equipment was washed and air-dried, then placed in a plastic bag, with the resident's name and date. On 08/26/25 at 01:25 PM, Administrative Nurse D stated all respiratory equipment should be cleaned and placed in a clear bag. She stated that clean laundry should always be transported covered and in a sanitary manner.The facility's Oxygen Administration Policy dated 05/18/24 directed to keep the delivery devices covered in a plastic bag when not in use.The facility's Handling Clean and Dirty Laundry policy dated documented it was the policy of the facility to handle, store, process, and transport clean and soiled linen in a safe and sanitary manner to prevent contamination of the linen, which can lead to infection. All used linen should be handled using standard precautions and treated as potentially contaminated. The facility's Legionella Surveillance policy dated 06/26/24 documented it was the policy of the facility to establish primary and secondary strategies for the prevention and control of Legionella infections.

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F 0881 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Implement a program that monitors antibiotic use. The facility identified a census of 34 residents. The sample included 12 residents. Based on observation, record review, and interviews, the facility failed to develop and implement the core elements of antibiotic stewardship to ensure an effective infection prevention and control program, including antibiotic stewardship for the residents of the facility.Findings included:- Review of the Infection Control Log for tracking and trending infections from August 2024 through July 2025 lacked evidence of organism identifications, duration of antibiotic prescribed, and the infections treated. The facility was unable to provide evidence of tracking upon request. On 08/25/25 at 02:17 PM, Administrative Staff A stated the facility was unable to locate the binder for antibiotic surveillance. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the facility was unable to locate more than the month of surveillance that had been provided. The facility's Antibiotic Stewardship policy, revised on 06/29/23, documented that the purpose of the policy was to optimize antibiotic use in the nursing facility. The facility would reduce the unnecessary use of laboratory tests using a systematic approach.

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F 0883 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Develop and implement policies and procedures for flu and pneumonia vaccinations. The facility identified a census of 34 residents. The sample included 12 residents, with five residents reviewed for immunizations. Based on observation, record review, and interviews, the facility failed to provide Resident (R) 6 with the Pneumococcal Conjugate Vaccine (PCV20- vaccination for bacterial lung infections) and the Influenza vaccine as consented. The facility further failed to offer the PCV20, and Influenza vaccines for R24 and R14. This placed the residents at increased risk for complications related to pneumococcal (a type of bacterial infection).Findings included:- R6's Electronic Medical Record (EMR) revealed he was eligible and within the required vaccination date range to receive the PCV20 vaccination. Review of Resident Consent for Immunization Form for R6 dated 01/23/25 provided by the facility revealed a signed consent to receive the pneumococcal vaccination and Influenza Immunization. The form indicated R6 was provided educational information related to the PCV20 vaccination and Influenza Immunization. R6's clinical record lacked evidence that R6 received the PCV20 vaccination and Influenza Immunization. Upon request, the facility was unable to provide evidence that the PCV20 and Influenza Immunization were administered to R6. Upon request, the facility was unable to provide evidence or documentation that R24 and R14 were offered the PCV20 and Influenza. On 08/25/25 at 01:13 PM, Administrative Staff A stated the facility was not able to find documentation for vaccines given or signed declinations. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the facility was unable to find documentation of vaccines. She stated there had been some staff changes, and she was unsure where the information was. The facility's Influenza and Pneumococcal Immunizations policy, revised on 05/14/24, documented that the purpose of the policy was to ensure all residents residing in the building were offered the influenza and pneumococcal immunization, to prevent infection and the spread of communicable diseases.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175435	A. Building B. Wing	08/26/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Anew Healthcare Holton	1121 W 7th Street Holton, KS 66436

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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 0887 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Educate residents and staff on COVID-19 vaccination, offer the COVID-19 vaccine to eligible residents and staff after education, and properly document each resident and staff member's vaccination status. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 34 residents. The sample included 12 residents, with five reviewed for immunization status. Based on record reviews and interviews, the facility failed to offer or obtain informed declinations or a physician-documented contraindication for the COVID-19 (an acute respiratory illness in humans caused by coronavirus, capable of producing severe symptoms and in some cases death) vaccinations for Resident (R) 2, R14, and R24. This deficient practice placed these residents at increased risk for COVID-19.Findings included:- Review of R2's clinical record revealed he was admitted on [DATE]. Review of R2's EMR under the Immunization tab lacked documentation of the COVID-19 vaccination offered or declined, and lacked documentation of a historical administration or physician-documented contraindication.Review of R14's clinical record revealed he was admitted on [DATE]. Review of R14's EMR under the Immunization tab lacked documentation of the COVID-19 vaccination offered or declined, and lacked documentation of a historical administration or physician-documented contraindication.Review of R24's clinical record revealed he was admitted on [DATE]. Review of R24's EMR under the Immunization tab lacked documentation of the COVID-19 vaccination offered or declined, and lacked documentation of a historical administration or physician-documented contraindication.Upon request for R2, R14, and R24's record of declination or administration of the COVID-19 vaccine, the facility was unable to provide a consent or declination for these residents. The facility was unable to provide a physician-documented contraindication. On 08/25/25 at 01:13 PM, Administrative Staff A stated the facility was not able to find documentation for vaccines given or signed declinations. On 08/26/25 at 01:25 PM, Administrative Nurse D stated the facility was unable to find documentation of vaccines. She stated there had been some staff changes, and she was unsure where the information was. The facility was unable to provide a policy related to the administration of COVID-19 vaccination.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175435	A. Building B. Wing	08/26/2025

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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 0925 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Make sure there is a pest control program to prevent/deal with mice, insects, or other pests. The facility had a census of 34 residents. Based on observation, interview, and record review, the facility failed to ensure effective pest control. This deficient practice placed the residents of the facility at risk for decreased health and wellness. Findings included: - On 08/24/25 at 08:05 AM, several flies were in the dining area, flying around the nutrition kitchenette. Two unidentified residents were swatting flies before getting their plate of breakfast. On 08/25/25 at 10:05 AM, more than ten flies were flying around the nurse's station. On 08/25/25 at 11:44 AM, in the kitchen, there were 10-15 flies on the plates and bowls. On 08/25/25 at 12:10 PM, Resident (R) 16 stated her partner at the table brings his fly swatter and kills flies. She stated there were always flies in the dining room. The facility's last pest control inspection reported that on 04/23/25, the provider sprayed for general pests. On 08/26/25 at 12:42 PM, Certified Medication Aide (CMA) R stated the facility did have more flies. CMA R stated the flies come in through the patio. CMA R stated it takes a long while for wheelchair residents to get outside to smoke. On 08/26/25 at 01:25 PM, License Nurse (LN) I stated there were a lot of flies, she stated she did not know if there was a pest control program for the flies. LN I stated the facility had several fly swatters. On 08/26/25 at 01:25 PM, Administrative Nurse D stated she was unaware of the fly problem. She stated that the maintenance personnel should be noting and taking care of the fly situation. The facility's Effective Pest Control Program policy dated 05/14/24 documented that it was the policy of the facility to maintain an effective pest control program that eradicated and contained household pests and rodents. The facility would maintain a written agreement with a qualified outside pest service to provide comprehensive pest control services regularly.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175435	A. Building B. Wing	08/26/2025

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F 0947 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Ensure nurse aides have the skills they need to care for residents, and give nurse aides education in dementia care and abuse prevention. The facility had a census of 34 residents. Two Certified Nurse Aides (CNA) were sampled for required in-service training. Based on record review and interview, the facility failed to ensure two of the two CNA staff reviewed had the required 12 hours of in-service education. This placed the residents at risk for decreased quality of life and/or inadequate care. Findings included:- Review of the facility's in-service records revealed the following CNAs were employed with the facility for more than 12 months: CNA M, hired on 06/20/24, had not completed the required in-services in the past 12 months. CNA N, hired on 04/24/24, had not completed the required in-services in the past 12 months. On 08/26/25 at 01:25 PM, Administrative Nurse D stated that the director of nursing and she would be responsible for ensuring the yearly required in-services had been completed. The facility failed to provide a policy related to required yearly in-services.