STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175446	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Halstead Health and Rehabilitation Center	915 McNair Street Halstead, KS 67056

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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 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. Based on observation, interview, and record review, the facility failed to provide sanitary conditions for food storage and preparation in the facility's one kitchen to prevent the spread of food borne illness to the residents of the facility. Findings included:- Initial tour of the kitchen on 04/13/2026 at 8:00 AM with Dietary Manager CC revealed the following areas of concern:Various containers and plates were not inverted on the drying rack in the kitchen which exposed the eating surfaces to potential contaminants.Two packages of cheese slices wrapped in plastic and one plastic bag with ham slices in the kitchen cooler with the dates 04/09 and 04/12, absent of year.One container with barbeque sauce dated 03/26; one large container of picante sauce dated 02/24; one large container of relish dated 03/24; one large container of Kens Ranch salad dressing dated 04/08/25 with no expiration date; one large container of mayonnaise dated 03/10; one large container of Reliance Italian dressing dated 03/03; one container of green olives dated 06/19; one large container with maraschino cherries with black mold all around the rim of the container and the inside to outside of lid with an open date of 06/05/25 written on lid; one large container of parmesan cheese dated 01/26; One squeeze bottle labeled mayonnaise with an unreadable date on label; two bottles of Smucker's caramel syrup dated 09/30; one Nestles strawberry syrup bottle dated 03/23; one container labeled soy sauce dated 03/15; one bottle of [NAME] wing sauce with an unreadable date; one large square container of green beans dated 04/12 use by 04/18 are absent of year.Two racks in the cooler had rust over the entire surface of the metal racks. A large portion of the white coating over the metal racks was chipped and/or peeled off.Two bags of frozen carrots dated 04/16; six pancakes wrapped in plastic dated 04/03; two waffles in plastic dated 04/03; one waffle wrapped in plastic, no undated; one unsealed plastic bag of chicken strips, undated. The spice rack had one open package of brown sugar undated; one clear container labeled turmeric, with an opened date of 11/06/23 and a use by date of 11/05/24; one clear container of black pepper opened on 02/01; one clear container with crushed red pepper flakes with an open date of 11/06/23 and a use by date of 11/05/24; one container of curry powder with an opened on 11/06/23 and use by 11/05/24.The walk-in cooler had one open bag of oranges, undated, and two small metal containers with the date 04/11 and use by 04/17, there is no year for dates.The pantry had an open box of croutons with two open bags of croutons inside the box. Dietary Staff CC threw away the box of croutons. Observed on 04/13/26 at 09:58 AM, one rice bin in the pantry with handwritten sticker showing rice prep date 07/29, no year. Observed on 04/14/26 8:16 AM, Dietary Staff DD used ungloved hands to hold butter, slice and toast bread then placed the toast on a hall tray plate to be served to a resident. Observed on 04/14/26 at 9:42 AM, one partially wrapped package of cheese slices in the cooler, not dated. Observed on 04/14/26 at 10:45 AM, Dietary Staff DD washed their hands under only running water using no soap or sanitizer, three times while pureeing food for lunch. Observed on 04/14/26 11:05 AM, Ecolab low heat dishwasher with the washing water temperature of 102 degrees. The dish machine temperature log for April 2026 revealed the following temperatures:04/01/26 92 degrees04/02/26 98 degrees04/03/26 107 degrees04/04/26 112 degrees04/05/26 108 degrees04/06/26 96 degrees04/07/26 115 degrees04/08/26 111 degrees04/09/26 107 degrees04/10/26 99 (continued on next page)

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	degrees04/11/26 91 degrees04/12/26 113 degrees04/13/26 119 degrees04/14/26 115 degrees04/15/26 103 degrees The dish machine temperature log dated April 2026 documented the supervisor should be notified if the dish machine temperature goes below 120 degrees. During an interview on 04/15/26 10:32 AM, Administrative Staff A and Dietary Staff CC stated gloves should be worn when handling ready-to-eat foods, such as bread for sandwiches or toast. Food stored or prepared in the kitchen including spices should be dated with the month, the day, and the year. All stored food in a bag, box, or container should also be sealed or closed and should be labeled with the month, day, and year. All packages of stored food should have the bag or the wrapping sealed and closed properly. All cooked food temperatures should be taken after food preparation, and the food temperature should be taken again before serving the food. Hand hygiene should be done with soap and water or hand sanitizer when preparing food. Dishes such as plates, containers, and bowls should always be inverted. They said they knew the cooler racks were bad and had ordered new ones, but the racks were on back order and should be there soon. They confirmed the dishwasher temperature should be at a minimum of 120 degrees during the wash cycle. Administrative Staff A and Dietary Staff CC stated they would have maintenance look at the dishwasher and possibly contact the manufacturer of the dishwasher if needed. They stated bags of food should always be sealed and properly dated when stored in the pantry, freezer, or cooler. During an interview on 4/15/26 at 11:28 AM, Administrative Staff A revealed they do not have an answer for the temperatures on the temperature log but stated that it sounded like the facility needed to have some education and initiate a performance improvement plan for staff regarding this topic. The facility's 04/06/20 Food Storage policy documented staff are to label all food items with the name of the food and the date it was opened or when it should be used by, and food which has passed the expiration date should be discarded. The facility did not provide a hand hygiene policy for dietary staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide and implement an infection prevention and control program. Based on observation and record review the facility failed to maintain an effective infection control program related to Enhanced Barrier Precaution (EBP- infection control interventions designed to reduce transmission of resistant organism which employ targeted gown and gloves use during high contact care) during wound care. Additionally, staff failed to keep laundry cart covered during delivery of clean clothing. Findings included:- An observation of tracheostomy care for Resident (R) 2 on 04/14/26 at 07:50 AM, revealed Licensed Nurse (LN) H performed hand hygiene, donned gloves, and wore a mask, LN H did not don a gown prior to providing cares and changing gloves before placing clean four by four gauze or the tracheostomy cannula (a tube to maintain a patient's airway for breathing). An observation on 04/14/26 at 11:35 AM, during the delivery of resident's personal items, revealed Housekeeping/Laundry Staff U placed the covered cart in hall 100, then took the items off the cart and carried the items over her shoulder to hall 200 without the cart, uncovered. During an observation on 04/14/26 at 12:37 PM, prior to doing wound care for R6, LN H performed hand hygiene and applied a gown and gloves. LN H then did the wound care and upon leaving the room after providing the wound care LN H reached down while holding the gauze and wound cleanser inspected and manipulated the suprapubic catheter (a tube inserted through the abdominal wall into the bladder to drain urine) tubing then left the room without performing hand hygiene. On 04/15/26 at 10:19 AM, LN I revealed wound care supplies should be kept in the residents' room or bagged and taken to the wound nurse and hand sanitizing should be performed before/after wound care and if soiled. On 04/16/26 at 08:00 AM, an interview with LN H revealed she should have changed gloves and wore a gown prior to tracheostomy care. On 04/15/26 at 08:04 AM, an interview with Administrative Staff D revealed she expected the staff to wear a gown, gloves, and a mask at minimum for EBP, and hand sanitizing should be completed after the dirty side is done and new gloves applied. On 04/16/26 at 10:10 AM, an interview with Administrative Staff D revealed she expected staff to follow the hand hygiene and glove use during catheter care and if touching a bag or catheter tubing, staff should perform hand hygiene. On 04/16/26 at 10:17 AM, an interview with Housekeeping Staff V revealed she expected the laundry staff to place the covered cart next to the room where they would deliver personal items to the residents and make sure the cart is covered between rooms. The facility's policy Enhanced Barrier Precautions (EBP) dated 04/1/24 Enhanced barrier precautions (EBP) refer to an infection control intervention designed to reduce transmission of multidrug-resistant organism that employs target gown and glove use during high contact resident care activities. The facility's policy Hand Hygiene, dated 11/28/17, documented staff are to wash hands with soap and water when hands are visibly soiled, cleanse hands with alcohol-based hand rub before and after contact with the resident, after contact with blood, body fluids or visibly contaminated surfaces or other objects, after removing personal protective equipment, before performing a procedure such as an invasive device urinary catheter and or dressing care.

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F 0641 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident receives an accurate assessment. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to accurately complete the [NAME] Data Set for Resident (R) 13. Findings included:- R13's Electronic Medical Record (EMR) documented diagnoses hemiparesis/hemiplegia (weakness and paralysis on one side of the body), chronic osteomyelitis (local or generalized infection of the bone and bone marrow), and intervertebral disc disorder (occurs when the discs between vertebrae are damaged or degenerate, leading to compression or irritation of nearby nerve roots.) with radiculopathy (pain, tingling, or weakness radiates along the affected nerve, often down the legs). R13's 03/24/26 Quarterly Minimum Data Set (MDS) documented a BIMS of 15. The MDS noted R13 required supervision for walking 10 feet and required partial assistance for walking 50 feet. The MDS incorrectly documented R13 had no falls since the previous MDS assessment. R13's Care Plan, dated 01/16/25, documented R13 continued to do things independently even when he had been educated several times to use his call light. R13's 01/16/26 General Note, under progress notes at 01:59 AM, documented staff went into R13's room because his call light was on and found him lying next to his heater on top of some boxes, papers, and his bed side table. R13 complained of back pain and left hip pain. R13 had swelling behind his left ear from hitting the heater and his left cheek was reddened. R13 reported tenderness when putting weight on his leg. The nurse encouraged R13 to go to the emergency room, but R13 refused. The provider was notified and gave an order for a hip x-ray and pain medication. R13's 01/16/26 Lab/Diagnostic Note, under progress notes at 08:33 AM, documented mobile X-ray came to the facility to x-ray R13's leg. The facility received the report of a nondisplaced fracture of the left superior pubic ramus, and the doctor was notified. She states that she will be at the facility within the hour and she will assess the resident. R13's 01/16/26 Lab/Diagnostic Note, under progress notes at 10:41 AM, documented the provider arrived to see R13. R13 refused a follow up CT and refused an orthopedic consultation. R13 stated if he decided that he needed additional assistance then he would consider therapy. The provider also explained R13 would not be a good surgical candidate. On 04/13/26 at 10:20 AM, R13 had been working on walking in the hall with therapy. Therapy assisted R13 back to his room. He sat in his wheelchair and reported he had falls and was working with therapy to get stronger after his last fall. On 04/15/26 at 8:46 AM, Administrative Nurse E stated she coded part of the MDS, but the regional nurse completed some of the coding which included the falls portion of the MDS. Administrative Nurse E agreed that R13 had a fall the resulted in a hip fracture and it should have been coded as a fall with major injury. Administrative Nurse E stated she would message the regional nurse and find out why she coded it like that. On 04/15/26 at 10:05 AM, Administrative Nurse E stated the regional nurse stated she coded it in error, and the regional nurse would complete a correction immediately. On 04/15/26 at 10:57 AM, Administrative Nurse D reported she expected the MDS to be completed accurately to accurately reflect the resident. The undated MDS policy documented the facility will conduct a comprehensive MDS assessment according to the Federal regulations and Medicare guidelines. The facility staff will follow the current Resident Assessment Instrument (RAI - a comprehensive, standardized tool used in long-term care facilities to assess residents, guide care planning, and monitor quality of care) manual for proper procedures on completing the MDS.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. Based on observation, interview, and record review, the facility failed to provide an environment free of accident hazards when staff failed to provide the necessary foot pedals when assisting propelling Resident (R)3 in a wheelchair. Findings included: - R3's Electronic Medical Records (EMR) documented diagnoses that included severe morbid obesity, vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and noncompliance. R3's 12/24/25 Significant Change Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The assessment documented R3 had one fall with minor injury since the previous assessment. R3's 12/24/25 Falls Care Area Assessment (CAA) documented R3 had falls in the previous three months and he was at risk for falls. R3's 3/10/26 Quarterly MDS documented a BIMS score of 15. The MDS documented R3 had one noninjury fall since the previous assessment and was independent with wheelchair mobility. R3's Care Plan, dated 01/10/24, documented R3 was at risk for falls. The plan instructed staff to ensure the walker was within reach. The plan was updated following a fall on 12/24/25. The plan also documented R3's back locked up at times and he needed a wheelchair. During an observation on 04/13/26 at 09:04 AM, Certified Nurse Aide (CNA) M pushed R3 in his wheelchair to his room, the wheelchair did not have foot pedals attached and R3's feet were crossed and R3 held his feet off the floor. R3 reported he was just coming in from smoking. During an observation on 04/14/26 at 07:42 AM, R3 attempted to go to the door to go out to smoke. Licensed Nurse (LN) HH stood in front of R3 and told him it was one and a half hours until the next smoking break. R3 got frustrated and told LN HH to turn him around in his wheelchair, then LN HH turned him around in the wheelchair and assisted him to the dining room. R3's sock was half off his foot and dragged the floor. R3 held his foot off the floor. During an interview on 04/14/26 at 07:48 AM, LN I stated she thought she should not have assisted R3 in the wheelchair without foot pedals on but was not sure. LN I then asked Certified Medication Aide (CMA) S if R3 required foot pedals when staff are pushing him in his wheelchair. CMA S stated R3 used the foot pedals when he was assisted in his wheelchair. If he is self-propelling, he does not need them. During an interview on 04/15/26 at 08:46 AM, Administrative Nurse E confirmed staff should not assist R3 in the wheelchair without foot pedals. During an interview on 04/15/26 at 10:57 AM, Administrative Nurse D stated that staff should use foot pedals when they are assisting residents in the wheelchair. The facility's undated Falls policy documented the residents would be assessed for risks of falls and interventions would be implemented to reduce risk of falls.

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F 0690 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate care for residents who are continent or incontinent of bowel/bladder, appropriate catheter care, and appropriate care to prevent urinary tract infections. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to provide appropriate care and treatment of a suprapubic catheter (tube surgically inserted through the abdominal wall into the bladder to drain urine) when staff anchored the suprapubic tubing to Resident (R)6's leg instead of his abdomen as indicated by current standards of practice to prevent pulling or dislodgement. Findings included: - R6's Electronic Medical Record (EMR) from the Diagnosis tab documented Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), chronic kidney disease-stage three (CKD), benign prostatic hyperplasia (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), obstructive uropathy (a structural or functional blockage in the urinary tract that prevents urine from flowing freely, causing it to back up and damage the kidneys), and retention of urine (the inability to fully or partially empty the bladder). R6's Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview of Mental Status (BIMS) score of four, which indicated severely impaired cognition. The MDS documented R6 had an indwelling catheter during the observation period. The Urinary Incontinence Care Area Assessment (CAA), dated 12/09/25, documented a diagnosis of Alzheimer's, obstructive and reflux uropathy, retention of urine, and BPH. R6's Care Plan, dated 08/25/23, documented an order from R6's urologist which directed staff not to remove R6's catheter. On 02/17/25, the plan directed staff were to apply Skin-prep (liquid skin barrier) prior to attaching the Stat-lock (adhesive medical tubing stabilization device) for the suprapubic catheter. During an observation on 04/14/26 at 12:37 PM, Licensed Nurse H assessed and cleaned the suprapubic catheter site on R6's abdomen. The Stat-lock was attached to R6's left upper thigh and was confirmed by Licensed Nurse H. During an observation on 04/15/26 at 9:22 AM, Licensed Nurse I assessed and cleaned the suprapubic catheter site on resident R6's abdomen, then attached a Stat-lock to R6's left upper thigh, securing the tubing from R6's abdomen. During an interview on 04/14/26 at 2:32 PM, Licensed Nurse H stated they were unaware of a Stat-lock being adhered to the abdomen and would ask the Administrative Nurse D for directions on where to place the Stat-lock for a suprapubic catheter. On 04/14/26 at 02:34 PM, Administrative Nurse D stated she would expect the Stat-lock to be anchored to the leg. During an interview on 04/14/26 at 02:43 PM, Administrative Nurse D stated the facility catheter policy does not state where to place a Stat-lock for a suprapubic catheter, however, the suprapubic catheter replacement competency states the tubing should be anchored to the abdomen. Administrative Nurse D stated they were unaware the competency checklist required the tubing to be anchored to the abdomen the previous times they reviewed the checklist. The facility competency checklist states the catheter tubing should be secured to the abdomen.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. Based on observation, interview, and record review, the facility failed to ensure nutritional maintenance for Resident (R) 27. The facility failed to follow the registered dietitian's recommendations for providing facility meal shakes to R27 three times daily and R27 had a 3.16% weight loss in 14 days. Findings included:- The Electronic Health Records (EHR) for R27 included diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion), chronic pain, unspecified intellectual disabilities, and major depressive disorder. R27's Quarterly Minimum Data Set (MDS), dated 03/17/26, documented a Brief Interview for Mental Status (BIMS) of three, which indicated severe cognitive impairment. The MDS also documented R27 used a wheelchair for mobility and required set-up or clean-up assistance for eating. The MDS documented R27 had a listed weight of 123 pounds (lbs.) and had coughing or choking during meals or swallowing medication. The MDS documented R27 had no weight loss or gain. R27's Care Plan, dated 01/03/23, documented a focus on his nutrition. Interventions dated 01/03/23 and 12/14/23 instructed staff to provide R27 with his diet as ordered and to provide him with snacks between meals. Interventions dated 05/22/24 documented R27 received Remeron (a medication used to treat major depressive disorder and increase appetite) and instructed staff to monitor R27 for loss of appetite. An intervention, dated 01/28/26, instructed staff to provide R27 a supplement as ordered. R27 had a Physician Order for regular diet with regular texture and consistency dated 10/16/23. R27 had a Physician Order for Remeron 15 milligrams (mg) at bedtime for depression that was dated 12/24/24. The Nutrition/Dietary Note, dated 03/03/26 with a time of 01:40 PM, documented, at that time, R27 had a weight 122.9 lbs. and had slow, unplanned weight loss trend related to a decline in energy. The note also documented a suggestion to offer R27 a house supplement three times a day (TID) and for staff to add extra sugar, cream, and butter to his food and fluids as needed to help increase R27's energy intake to promote weight stability. R27's Nutrition - Liquid House Supplement Task documented, from 03/16/26 to 04/13/26, R27 was offered and received a supplement drink one time daily in the afternoons. R27's EHR documented a weight of 123.4 lbs. on 04/01/26 and a weight of 168.0 lbs. on 04/10/26. On 04/14/26 at 08:12 AM, observed kitchen staff talking and assisting R27 pick his breakfast meal. Observed on 04/14/26 at 08:21 AM, R27 was sitting in the dining room eating cereal in milk, drinking orange juice and coffee, he did not eat his scrambled eggs. Observed on 04/15/26 at 10:25 AM, R27 was weighed in his wheelchair, staff zeroed the scale, he remained still, and a weight of 166.2 lbs. was obtained. The CNA then weighed the wheelchair itself and obtained a weight of 46.7 lbs., and she deducted this from the initial weight for a recorded weight of 119.5 lbs. for R27, this was a 3.9 lb. loss of weight since 04/01/26, a 3.16% decline. On 04/14/26 at 08:22 AM, Dietary DD stated R27's breakfast meal was scrambled eggs, sausage, cheerios, orange juice, and coffee, and sugar was added to the coffee and cereal. She also said R27 was not on any special diet, and the house supplement was made by the kitchen and then offered to R27 by the Certified Medication Aide (CMA). On 04/14/26 at 08:43 AM, CMA R stated R27 only received a supplement on the second shift around 02:00 PM daily. On 04/14/26 at 09:23 AM, Licensed Nurse (LN) H verified R27's weight for 04/10/26 was listed as 168 lbs. and stated she was unaware of the significant weight difference from 123.4 lbs. documented on 04/01/26, then stated the weight should have been re-checked. She then said R27 would be re-weighed properly, and the wheelchair probably had not been deducted from the weight. On 04/14/26 at 09:49 AM, Dietary CC stated when the dietician would suggest dietary supplements such as health shakes, it would then be presented to the MDS Coordinator who would then place that order in the chart so that staff could provide it to the residents. On 04/14/26 at 10:26 AM, Administrative Nurse E stated the dietician recommendations were put in the tasks after review by the Interdisciplinary Team (IDT), then she would put the follow up note linked to the dietary note. She said she missed the dietitian recommendation for R27 to receive house supplement shakes TID and entered them into the EHR for only one time a day. On (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/14/26 at 11:20 AM, Dietary BB stated she was not aware that her recommendation on 03/03/26 for R27 to have house shakes TID was changed to one time a day by the facility. She said she would be involved in the change of recommendation, depending on the resident, but was not currently aware that R27's recommendation had been changed. On 04/15/26 at 11:06 AM, Administrative Nurse D and Administrative Nurse E stated the 168 lb. weight should have been reported immediately to the nurse and a re-weight should have been performed for verification, she further stated whoever weighed R27 was to review the previous weight and perform a re-weight if there was a significant change. Administrative Nurse E then stated on 01/15/26 R27 had a task ordered for weekly weights. The facility policy Weight Loss Prevention, dated 04/20/20, documented that residents with poor or declining nutritional intake, weight loss, BMI <22 and/or pressure ulcers would have nutritional interventions added as needed and the Registered Dietitian should be consulted.

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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** Based on observation, interview, and record review, the facility failed to ensure emergency equipment, that included an Ambu bag (a handheld, manual, self-inflating resuscitator used to deliver positive pressure ventilation to patients with inadequate or no breathing) was readily available in the event of an accidental extubation (removal of a medical tube) of Resident (R)2's tracheostomy (opening through the neck into the trachea through which an indwelling tube may be inserted) cannula. Findings included:- The Electronic Health Records (EHR) for R2 included diagnoses of sleep apnea (a disorder of sleep characterized by periods without respirations), encounter for attention to tracheostomy (care, cleaning, and maintenance of the artificial opening in the throat used for breathing), obesity (excessive body fat), dysphagia (swallowing difficulty), malignant neoplasm of nasopharynx (an uncommon, often aggressive cancer starting in the upper throat behind the nose), and chronic respiratory failure with hypoxia a long-term, progressive condition where the lungs cannot adequately transfer oxygen to the blood). R2's Significant Change Minimum Data Set (MDS), dated for [DATE], documented a Brief Interview for Mental Status (BIMS) of 15, which indicated cognitively intact. The MDS documented R2 used a wheelchair for mobility, was dependent on staff for applying footwear, required partial to moderate staff assistance for dressing his lower body, set-up or clean-up assistance for bathing and oral hygiene, and he was independent for all other activities of daily living (ADL). The MDS also documented that R7 required oxygen therapy and tracheostomy care. The Psychotropic Drug Use Care Area Assessment (CAA), dated [DATE], documented R2 was taking antianxiety (a class of medications that calm and relax people) and antidepressant (a class of medications used to treat mood disorders) medication. R2's Quarterly MDS, dated [DATE], documented a BIMS of 15. The MDS also documented R2 used a wheelchair for mobility; R2 was independent for eating and dressing his upper body, required set-up or clean-up assistance for oral and personal hygiene, and R2 was dependent on staff for all other ADL. The MDS also documented R2 that required oxygen therapy and tracheostomy care. R2's Care Plan, revised date of [DATE], documented R2 had respiratory-tracheostomy care and oxygen with an intervention which documented R2 received breathing treatments and would take them off himself; staff were to remind R2 to notify them when the treatment was finished. R2's Care Plan documented interventions, dated [DATE], that staff were to contact his physician immediately if R2 began to have trouble breathing through his stoma (a surgically created opening in the neck leading to the trachea, allowing a tube to be inserted for breathing). Staff were also instructed to provide R2 oxygen with a tracheostomy mask (a soft plastic device worn around the neck to deliver humidified oxygen directly to a tracheostomy tube). R2's Care Plan documented an intervention, dated [DATE], that instructed staff to provide R2 suction whenever it was indicated. R2's Care Plan documented an intervention, dated [DATE], that the inner cannula size of R2's tracheostomy tube was 6.0 millimeters (mm) extended length tracheostomy (XLT). R2's Care Plan had interventions dated [DATE] and [DATE] which instructed staff to call 911, per a physician order, if the entire tracheostomy tube came out and staff were to follow the Emergency Protocol Health (EPH) policy. R2's EHR had an active, undated, order which instructed staff to call 911 and send R2 to the emergency room (ER) if the entire tracheostomy came out. Observed on [DATE] at 9:48 AM, there was oxygen and suction readily available at R2's bedside but there was no Ambu bag available in the room. The emergency supplies and Ambu bag were located on a covered cart in the hallway against the wall, between the legs of the Hoyer (total body mechanical lift). The battery charger for the Hoyer was sitting on top of the cart and plugged in. Observed on [DATE] at 07:45 AM, there was no Ambu bag available in R2's room. On [DATE] at 02:36 PM, Certified Nurse Aide (CNA) K, stated that the nurse performed tracheostomy care on R2. CNA K also said if R2 went into respiratory distress while cares were performed, he would be sat up and the nurse notified. On [DATE] at 02:42 PM, Licensed Nurse (LN) G stated all nurses were (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175446	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Halstead Health and Rehabilitation Center	915 McNair Street Halstead, KS 67056

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	cardiopulmonary resuscitation (CPR- an emergency lifesaving procedure performed when the heart stops beating) qualified in the facility and confirmed R2's emergency tracheostomy supplies and Ambu bag were not readily available at the bedside. LN G said the emergency supplies were kept in the hallway under the Hoyer lift and in the medication room. LN G also stated that hospice residents with a tracheostomy had an emergency kit and equipment at the bedside because hospice provided those supplies. On [DATE] at 02:50 PM, Administrative Nurse D stated tracheostomy care competency was performed annually for the nursing staff. Administrative Nurse D also stated there was not an available emergency kit or Ambu bag at bedside because staff were told by the physician not to reinsert the tracheostomy if it came out, staff were to immediately call 911. On [DATE] at 08:04 AM, Administrative Nurse D said the Ambu bag was directly outside R2's room on the crash cart, not at the bedside. She verified that if staff needed the Ambu bag because R2 was in respiratory distress, staff would have to move the Hoyer lift, uncover the cart, and wheel it into the room. The facility policy Respiratory Care, dated [DATE], documented the facility provided necessary respiratory care and services in accordance with professional standards of practice, the resident's care plan, and the resident's choice.

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F 0628 Level of Harm - Potential for minimal harm Residents Affected - Many	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on interviews and record reviews, the facility failed to provide written notification to the Office of the Long-Term Care Ombudsman (LTCO) regarding six residents transferred from the facility, five transferred home and one resident transferred to another facility. Findings included:- Review of the admission/discharge report from 02/14/26 to 04/14/26 indicated one resident transferred to another facility and five residents transferred home. On 04/14/26 at 10:25 AM an interview with Social Service X revealed the only time she notifies the LTCO is when a resident is transferred to the hospital. She has not notified the LTCO with residents transferring to home or another facility. On 04/15/26 at 11:15 AM, an interview with Administrative Staff A revealed she expected any transfers from the facility to be sent to the ombudsman. The facility did not provide a policy regarding notification of the ombudsman on transfers to another facility or to home upon request.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the posted daily nurse staffing sheets included accurate and identifiable information to include the name of the facility and total hours worked, as required. Findings included:- Observed on 04/13/26 at 08:00 AM, the posted staffing sheet lacked the total hours worked. Observed on 04/14/26 at 09:30 AM, the posted staffing sheet lacked the total hours worked and did not list the facility name. Review of the daily staffing sheets from 05/13/25 and 03/18/26 revealed the posted staffing sheets lacked the total hours worked. During an interview on 04/14/26 at 11:48, Administrative Nurse D stated the nightshift nurse filled out the next day staffing sheet and then posted it for display before the start of the next shift. Administrative Nurse D also said the listed column that was labeled actual hours were the total hours worked. The facility policy Daily Nurse Staff Posting, dated 11/28/17, documented at the beginning of each shift the charge nurse would compute the number of full-time equivalents on duty and record the number on the Daily Nurse Staffing form. The form would then be posted in designated locations in such a manner that it could be easily seen and read. The policy also documented the facility census would be recorded on the form and be updated with any admissions or discharges throughout the day.