STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175451	A. Building B. Wing	01/08/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Wheat State Manor	601 S Main St Whitewater, KS 67154

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 0620 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Not require residents to give up Medicare or Medicaid benefits, or pay privately as a condition of admission; and must tell residents what care they do not provide. The facility identified a census of 31 residents. The sample included 12 residents. Based on record reviews and interviews, the facility failed to establish and implement an admissions agreement that protected residents' right to personal property when the facility's admission agreement, signed by residents or their representatives at time of admission, asked the resident to waive facility responsibility for loss of personal property while being a resident in the facility.Findings included:- The facility's admission and Care Agreement revealed under Resident's Valuables on page eight, the Care Center maintains a secure area where personal articles of small size and limited dollar value may be stored. It is agreed by all parties that money, jewelry, documents, furs, and other personal articles of significant monetary value which are brought into the Care Center by the resident and third parties are in violation of the paragraph and shall not be the responsibility of the Care Center. During an interview on 01/08/26 at 09:45 AM, Administrative Staff A stated the admission Agreement statement was incorrect and would be removed. Administrative Staff A said residents were encouraged not to bring highly valuable items, but lock boxes were provided and encouraged for use, and the agreement would be changed immediately. Administrative Staff A further stated residents were allowed to bring and have whatever valuables they would like. The facility's admission Agreement policy, last revised August 2018, directed the facility did not ask or require residents/potential residents to waive facility liability of personal property. The facility policy Resident Funds and Valuables Policy, dated 06/21/17, documented valuables would be inventoried, but it was suggested valuables not be brought to the facility.

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

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

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F 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 reported a census of 31 residents. The sample included 12 residents. Based on observation, interview and record review, the facility failed to use adequate hand hygiene when caring for residents including during a dressing change and intravenous (IV-administered directly into the bloodstream via a vein) treatment. Findings included:- On 01/07/26 at 11:46 AM, Licensed Nurse (LN) I obtained scissors from the desk and other dressing supplies from the cart. Without cleaning the scissors, LN I entered Resident (R) 33's room, washed her hands, and applied gloves. LN I removed R33's sock and removed the old bandage. LN I poured normal saline into a cup with gauze and washed the wound. Wearing the same soiled gloves, LN I applied normal saline to a Hydrofera Blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast), cut it to size and placed it on the wound, then placed the Optifoam dressing (a multi-layered, silicone-bordered foam dressing for advanced wound care, used for partial to full-thickness wounds with moderate drainage, preventing skin breakdown from friction and shear, and promoting a moist healing environment) over the wound. LN I then threw away the trash, removed her gloves, and grabbed the supplies which were not used. LN I took the supplies with her to the bathroom and laid them on the back of the commode as she washed her hands. She then took the supplies and returned them to the cart. On 01/08/26 at 01:08 PM, LN G entered R34's room to administer his intravenous (IV-administered directly into the bloodstream via a vein) antibiotic. LN G verified the medication rights and placed the medications along with a syringe of normal saline and alcohol pads into a basket. At the entrance, LN G donned gloves and a gown without performing hand hygiene first. LN G entered the room and placed the basket on the bedside table. LN G then touched the bed and bedding with her right gloved hand and proceeded to hang the bag of medication on the IV pole and set up the line and pump. Wearing the same gloves, LN G opened an alcohol pad, cleaned the hub of R34's peripherally inserted central catheter (PICC-a thin, flexible tube which is inserted into a vein in the upper arm and threaded into a large vein above the heart), and attempted to attach the syringe, but accidentally dropped it, and it fell into the trash can. LN G explained to R34 she would need to leave and get another syringe. LN G removed her gown and hung it on a hook in the room, and then removed her gloves. She exited R34's room without performing hand hygiene, walked to another hall, entered the Injection Room, obtained a new syringe of normal saline, then went back to R34's room. LN G then donned gloves, again without performing hand hygiene, entered R34's room, donned her gown, and proceeded to flush R34's PICC line and start administration of the IV antibiotic. After the initiation of the IV medication and wearing the same gloves, she emptied R34's catheter urine collection bag. LN G did not clean the urine collection port before or after access. LN G dumped the urine in the bathroom, removed her gown and gloves, then exited the room. She did not perform hand hygiene but proceeded to unlock the medication cart and place supplies in it. On 01/07/26 at 11:46 AM, LN I could not think of anything she did wrong, but said she understood hand washing and changing gloves needed to be done after touching any dirty surface and before touching a clean surface. LN I confirmed supplies needed to be cleaned prior to using them to cut dressings, and supplies cannot be taken out of a resident's room and returned to the cart. On 01/08/2026 2:25 PM, Administrative Nurse D stated she expected staff to use appropriate hand hygiene, which included hand hygiene after removing soiled gloves prior to putting on clean gloves during care. Administrative Nurse D stated supplies were not to be taken from a resident's room and returned to the cart, and reusable equipment was to be sanitized between uses. Administrative Nurse D said she expected excellent infection control practices for wound care and IV medication administration. The facility's policy Handwashing/Hand Hygiene, undated, documented the facility considered hand hygiene the primary means to prevent the spread of healthcare-associated infections. Hand hygiene was to be performed immediately before and after touching a resident, before performing an aseptic task, after contact with blood, body fluids, or contaminated surfaces; after touching a resident's environment, between work on a soiled body part (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	and a clean body part, and immediately after glove removal. The facility's policy Wound Care, undated, documented staff should remove gloves after removing the dressing and wash their hands. Clean reusable supplies like scissors with alcohol and return. Do not return disposable items to the drawer.

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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 reported a census of 31 residents. Based on interview and record review the facility failed to implement an effective antibiotic stewardship program that included an effective system to monitor antibiotic use, and/or an effective system to track and trend infections in the building for the facility's Infection Prevention and Control Program (IPCP). Findings included:- During an interview on 01/08/26 at 2:25 PM, Administrative Staff D stated at the time the facility did not have an effective infection control program, which included an Antibiotic Stewardship Program. Administrative Nurse D stated she was working on starting logs but had not started them yet. Administrative Nurse D stated the doctor tried to enforce the McGeer criteria (a set of surveillance definitions for infections in long-term care facilities) for documenting the appropriateness of antibiotics, but acknowledged if a resident saw another doctor, they would give what the other doctor prescribed, even if it did not meet the criteria. The Policies and Procedures- Infection Prevention and Control, undated, documented the objective of the policy is to monitor, prevent, detect, investigate, and control infections in the facility and to maintain a safe, sanitary place.

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F 0919 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Make sure that a working call system is available in each resident's bathroom and bathing area. The facility identified a census of 31 residents over four resident halls. Based on observation, record review, and interviews, the facility failed to ensure an adequate resident call system when the two call light visual display monitors, which were the only alert system for resident bedroom and bathroom call lights, were left unmonitored resulting in extended call light response times. Finding included:- Observation on 01/06/26 at 07:55 AM revealed an egressed nurse station on the 200-hall. A display monitor on the station displayed call requests. There was no staff present at the station. Observation on 01/06/26 at 07:56 AM revealed another egressed nurse station on the 400-hall. A display monitor on the station displayed call requests. There was no staff present at the station. Observation on 01/07/26 at 01:13 PM in the egressed nurse station on the 200-hall revealed there was no staff present at the station. Observation on 01/07/26 at 01:13 PM in the egressed nurse station on the 400-hall revealed there was no staff present at the station. The call light display monitor showed a help call alert from Resident (R) 27's room, which indicated the light had been on 35 minutes and 17 seconds. Another help call indicator listed R33's call light had been activated for 24 minutes and 49 seconds. Review of the facility's Call Light Log revealed the lights were last checked in December 2025 with no issues noted. On 01/07/26 at 12:40 PM, Certified Nurse Aide (CNA) M stated staff had to walk by the monitors to know whether a resident's call light was activated. She said there were only two monitors, one in the 200 hall and one in the 400 hall. She confirmed there was no other way to know the lights were activated, as there were no audible alarms or lights on the individual rooms or halls to indicate a call for help. CNA M said there used to be another monitor on the 100 hall, but it been removed. She verified the staff were not always present at the stations where the displays were and said it was sometimes a real problem to know which lights were going off, and said whoever walks by and sees it might call it out on the walkie (two-way radio). She stated the staff were advocating for more display screens in the other halls. On 01/08/26 at 09:45 AM, Administrative Staff A stated the facility was moving the display monitor from the 200-hall to the centralized nurse station in the main lobby area. He confirmed the display monitor was typically at the 200-hall nurse cubby. Administrative Staff A stated staff were visually alerted to a resident help call when they walked by the monitors; he verified there was no audible or other way to know the call light was activated. Administrative Staff A stated moving the 200-hall monitor to the main nurse station would allow the nurse to monitor the display and make a call out if a light was activated, instead of staff having to walk by the board. The facility did not provide a policy.

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F 0552 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure that residents are fully informed and understand their health status, care and treatments. The facility reported a census of 31 residents, the sample included 12 residents. Based on interview and record review, the facility failed to inform Resident (R) 6, R2, R4, R5 and R28 and/or their representative regarding the risks related to psychotropic (alters mood or thoughts) medications. Findings included:- Review of both Electronic Medical Record (EMR) and paper records revealed the following: 1. R6's EMR under the Orders tab revealed orders for the following:Sertraline HCL (an antidepressant medication), 150 milligrams (mg) one time a day for depression, dated 08/14/25.R8's scanned documents in the EMR did not contain consent forms for the above listed medications and lacked evidence of informed consent. 2. R2's EMR Orders tab revealed orders for the following:Bupropion oral tablet extended release 24-hour (a medication used to treat anxiety and depression), 150 mg by mouth one time a day related to generalized anxiety disorder.Lemborexant (a medication used to treat sleeplessness), 5 mg every 24 hours as needed for insomnia (inability to sleep) for 30 days each night as needed for sleep up to 30 days, dated 12/11/25.R2's scanned documents in the EMR did not contain consent forms for the above listed medications and lacked evidence of informed consent. 3. R4's EMR Orders tab revealed orders for the following:Bupropion oral tablet extended release 24-hour, 150 mg by mouth one time a day for depression, dated 09/13/24.Fluoxetine HCL (a medication used to treat depression and obsessive-compulsive disorder [OCD]), 20 mg one time a day for OCD, dated 03/12/19.Risperdal (am antipsychotic medication), 0.5 mg two times a day for OCD, dated 08/01/24.R4's scanned documents in the EMR did not contain consent forms for the above listed medications and lacked evidence of informed consent. 4. R5's EMR, under the Orders tab revealed the following orders:Ativan (antianxiety medication)0.5 mg, give 0.5 mg three times daily for anxiety and give 0.5 mg every eight hours as needed for anxiety for six months, dated 09/26/25.Zoloft (antidepressant medication) 100 mg one time daily for depression, dated 09/19/25R5's scanned documents in the EMR did not contain consent forms for the above listed medications and lacked evidence of informed consent. 5. R28's EMR, under the Orders tab revealed the following orders:Remeron (a medication used to treat depression), 15 mg, one time a day for depression, dated 8/18/24.Seroquel (an antipsychotic medication), 25 mg, 0.5 tablet by (12.5 mg), one time a day for dementia with behaviors, dated 10/10/25.Seroquel oral tablet 25 mg two times a day, for dementia with behavior, dated 10/10/25.Zoloft (a medication used to treat depression), 100 mg, one time a day for depression, dated 5/29/24.R28's scanned documents in the EMR did not contain consent forms for the above listed medications and lacked evidence of informed consent. During an interview on 01/07/26 at 04:22 PM, Social Services X stated there were no informed consents for psychotropic medications. During an interview on 01/08/26 at 10:03 AM, Administrative Nurse D stated the resident or legal representative were to be notified before any psychotropic medication was to be started and it was only required to be done before starting a psychotropic medication. Administrative Nurse D also stated every time the medication was to change then the resident or legal representative would be informed of the change. Administrative Nurse D further stated the nurse who received the order and the social services designee were to perform the notification and informed consent procedures for psychotropic medications. The facility policy Psychotropic Medication Use, dated 02/2025, documented prior to initiating the use of, increasing the dose, or switching to a different psychotropic medication, the staff and physician would review non-pharmacological alternatives, the indications and rational for the recommendation, the potential risks and benefits, and the resident's and/or representative's right to accept or decline treatment, prior to obtaining documented consent or refusal.

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F 0561 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Honor the resident's right to and the facility must promote and facilitate resident self-determination through support of resident choice. The facility reported a census of 31 residents, the sample included 12 residents. The facility failed to allow and facilitate residents to exercise dining preferences related to timing of receiving room trays and eating in the room versus the main dining area. Findings included:- Observed on 01/06/26 at 12:13 PM, Resident (R) 14 received his lunch tray in his room. R14 received chicken noodle soup. The bowel had a clear wrap and foil over it. R14 reported the soup was barely warm. During an interview on 01/06/26 at 11:15 AM, R6 reported he now goes to the dining room to eat because it would take a long time to get his food in his room, and the food would not be hot, but he preferred to eat in his room. During an interview on 01/06/26 at 12:06 PM, R14 reported he started eating in the dining room because it took a long time to get his food to his room, and the food would not be hot, and his lunch would not arrive until after 12:00 PM. R14 further stated the residents who ate in their rooms ate last, after the kitchen closed. During an interview on 01/06/26 at 12:29 PM, R9 reported he used to eat in his room, and staff told him he was not supposed to eat in his room, so he started going to the dining room. During an interview on 01/08/26 at 09:07 AM, Certified Nurse Aide (CNA) M stated the facility had made a rule stating residents who ate in their rooms were to receive their meal trays last, after everyone in the dining area was served. During an interview on 01/08/26 at 09:45 AM, Administrative Staff A stated if there was a reason for a resident to stay in their room or choose to, then they could, and there was no rule or policy related to serving meal trays last to those residents who had chosen to remain in their rooms. Administrative Staff A also stated he had told the staff it was easier to feed the dining room residents first, so it had been recommended to the staff to implement time management strategies when providing food trays to the residents. Administrative Staff A stated he expected staff to discuss the residents' preferences and acknowledge any circumstances or preferences which would indicate the resident should receive their room tray earlier, and staff should accommodate the residents' preferences. The facility policy Resident Rights, dated 10/2025, documented federal and state laws guaranteed basic rights to all residents of the facility, including the resident's right to self-determination and to be treated with respect, kindness, and dignity.

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility reported a census of 31 residents; the sample included 12 residents. Based on interview, observation, and record review, the facility failed to protect the dignity of resident (R) 8; when he was transferred through the facility without a dignity cover on his urine collection bag, leaving his urine visible to other residents and visitors. Findings included:- The Electronic Health Record (EHR) for R8 included the diagnoses of: benign prostatic hyperplasia with lower urinary tract symptoms (BPH-non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), overactive bladder (a sudden, uncontrollable urge to urinate, often leading to frequent bathroom trips and sometimes urine leakage), and urinary retention (lack of ability to urinate and empty the bladder). The Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of three, which indicated severe cognitive impairment. The assessment documented R8 using a wheelchair for mobility, and R8 was dependent on staff for all care and activities of daily living (ADL). The bladder and bowel section documented yes for R8 having an indwelling urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag). Observed on 01/07/26 at 01:00 PM, R8 sat in his Broda chair (specialized chair with the ability to tilt and recline) next to the fireplace in the front lobby area, across from the entryway and the nurse's station. R8's urine collection bag was visible under the footrest. The bag did not have a dignity cover and was approximately half full of pale-yellow urine. Observed on 01/07/26 at 01:30 PM, Certified Nurse Aide (CNA) O pushed R8 in his Broda chair from the 100 Hall to the main lobby area. R8's urine collection bag hung under the footrest. The bag lacked a dignity cover, and pale-yellow urine was visible. During an interview on 01/08/26 at 08:06 AM, CNA N stated the urinary collection bag should have been placed below the bladder and should have been covered or in a dignity bag. During an interview on 01/08/26 at 08:14 AM, Administrative Nurse D stated the urinary catheter collection bag should have been placed below the level of the bladder with a cover or in a dignity bag. The facility policy Resident Rights, dated 10/2025, documented federal and state laws guaranteed certain basic rights to all residents of the facility and included the resident's right to a dignified existence.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. The facility had a census of 31 residents. The sample included 12 residents with three residents reviewed for hospitalization. Based on interview and record review, the facility failed to provide a bed hold and written notification transfer for Resident (R) 30. The facility additionally failed to notify the Office of the Long-Term Care Ombudsman (LTCO). This placed the resident at risk for impaired rights related to returning to the facility. Findings included:- R30's Electronic Medical Record (EMR) revealed diagnoses of congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), paroxysmal atrial fibrillation (rapid, irregular heartbeat), and the presence of a cardiac pacemaker (an implanted device to regulate the beating of the heart). R30's Discharge with Expected Return Minimum Data Set (MDS) dated 11/09/25 had not documented a Brief Interview of Mental Status (BIMS). The health conditions section documented R30 had shortness of breath or trouble breathing at rest and with exertion. R30's Care Plan documented on 10/21/25 R30 had an altered cardiovascular status related to having a pacemaker, heart failure, and coronary artery disease (CAD- an abnormal condition may affect the flow of oxygen to the heart). The care plan interventions, dated 11/06/25, included instructions for staff to monitor, document, and report, as needed, any changes in lung sounds on auscultation (listening), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and weight. The Progress Notes dated 11/09/25 at 12:34 PM, documented R30 continued to have fluid retention, shortness of breath (SOB), her oxygen saturation was 90% on room air, and she only voided once that morning. The note further documented R30's representative was there and agreed R30 needed to go back to the hospital for evaluation and treatment; R30 was taken back to the emergency room via Emergency Medical Service (EMS). The Progress Notes dated 11/09/25 at 02:47 PM documented R30 was admitted to the hospital. R30's EMR lacked evidence the facility provided written notification of the transfer and a bed hold notice to R30 and/or her representative. The facility was unable to provide evidence of notification to the LTCO for R30's transfer. During an interview on 01/07/26 at 01:02 PM, Social Services X stated a bed-hold had not been done or sent for R30's discharge, and there had been no discharge notification sent to the Ombudsman or the family. During an interview on 01/07/26 at 01:08 PM, Administrative Nurse D stated the social services designee (SSD) had been responsible for initiating the bed hold, and it should have been done within 24 hours of the discharge. Administrative Nurse D further reported she was not aware the resident and/or family were to have been notified in writing of the transfer or discharge. The facility did not provide a policy related to bed hold and notification of resident transfers or discharge.

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident?s preferences and goals. The facility identified a census of 31 residents. The sample included five residents with five residents sampled for quality of care. Based on observation, interview, and record review, the facility failed to provide care and services for no pressure related skin issues for Resident (R) 33 when staff failed to change the dressing as ordered by the physician. Findings included:- R33's Electronic Medical Record (EMR) revealed the following diagnoses: dementia (a progressive mental disorder characterized by failing memory and confusion), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), and depression (a mood disorder which causes a persistent feeling of sadness and loss of interest). R33's 11/21/25 admission Minimum Data Set (MDS) documented a Brief Interview for Mental Status (BIMS) of 12, indicating moderate cognitive impairment. The MDS recorded R33 had no wounds or treatments. R33's Admission/re-admission Data Collection - V 4.0 dated 01/01/26 for R33's readmission documented a wound to the bottom of R33's left foot. R33's Care Plan dated 01/01/26 documented R33 had a potential or actual skin impairment, and staff were to use caution when transferring R33. The plan lacked mention of any wounds. R33's Physician's Orders documented an order to cleanse the left foot wound with normal saline and pat dry with gauze. Apply Hydrofera Blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast), cover with Optifoam dressing (a multi-layered, silicone-bordered foam dressing for advanced wound care, used for partial to full-thickness wounds with moderate drainage, preventing skin breakdown from friction and shear, and promoting a moist healing environment) Change the dressing every Monday, Wednesday, and Friday. Ordered on 01/01/26. The start date was 01/02/25. R33's Other Progress Note dated 11/29/25 at 02:06 PM documented R33 reported his left foot was hurting. He stated he stepped on a nail prior to moving to the facility. A photo of the foot was sent to the doctor. R33's January 2026 Medication Administration Record (MAR) documented the dressing change was not completed on 01/02/26 or 01/05/26. On 01/07/26 at 08:21 AM, R33 laid on the bed with a dressing on his foot dated 01/01/26. On 01/07/26 at 11:46 AM, Licensed Nurse (LN) I removed the dressing which was dated 01/01/26. She verified it was dated 01/01/26 and verified the order read to be changed on Monday, Wednesday, and Friday. LN I confirmed it appeared the dressing had not been changed in a week. When LN I removed the dressing, there was no Hydrofera Blue present. On 01/08/26 at 10:29 AM, Administrative Nurse D stated the nurses should complete the treatments as ordered and document. The facility's policy Wounds, Clean/Dry documented to verify the order prior to completing a dressing change and to document after it is 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 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility identified a census of 31 residents; the sample included 12 residents with six reviewed for accident hazards. Based on observation, interview, and record review, the facility failed to provide an environment free from accident hazards for Resident (R)11 when staff did not ensure the resident had a call light within reach and propelled the residents in a wheelchair without foot pedals. Findings included:- R11's Electronic Medical Record (EMR) recorded diagnoses of dementia (a progressive mental disorder characterized by failing memory and confusion) and osteoporosis (chronic arthritis without inflammation). R11's Quarterly Minimum Data Set (MDS) dated [DATE] recorded a Brief Interview for Mental Status (BIMS) score of zero, indicating severely impaired cognition. The MDS recorded she had behaviors and wandered during the observation period. R11 required staff assistance with activities of daily living. The MDS noted she had two or more falls since the last assessment, one resulting in an injury. R11's Care Plan noted an intervention dated 02/06/25, which directed staff to ensure R11's call light was within reach and encourage her to use it as needed. The plan recorded an intervention revised on 07/31/25 recorded R11 was dependent on staff assistance for mobility in a wheelchair for distances. On 01/06/26 at 10:03 AM, R11 sat on the edge. She attempted to stand but was unable, only raising a few inches off the bed, then sat down again. She reached out her arms toward the surveyor and appeared to be asking for help. She continued to rock forward as though she were attempting to stand. Observation revealed R11's call light was coiled at the foot of the full-sized bed on the opposite side of the resident. The call button had dropped between the bed and the wall and was not within reach of the resident. At 10:14 AM, Certified Nurse Aide (CNA) M entered the room in response to the surveyor's call for assistance and stated the resident sometimes threw the call light towards the end of the bed. She said R11 had not been feeling well and had been vomiting and having loose stools the previous day. CNA M reached down between the bed and the wall and retrieved R11's call light. On 01/08/26 at 10:58 AM, Certified Medication Aide (CMA) R pushed R11 in her wheelchair. R11 wore socks, and her wheelchair did not have foot pedals. R11 pedaled her feet, which lightly touched the floor, as staff propelled her in the wheelchair. On 01/09/26 at 07:30 AM, R11 sat in the main lobby, sitting in her wheelchair with both feet resting on the wheelchair foot pedals. On 01/08/26 at 11:02 AM, CMA R stated R11 occasionally self-propelled her wheelchair, so she does not need foot pedals, but confirmed if staff propel the chair. Foot pedals should be placed on the wheelchair at that time. CMA R stated R11 needed to use the bathroom, so she assisted R11 by pushing the wheelchair even though there were no pedals on the chair. On 01/08/26 at 12:24 PM, Administrative Nurse D stated she expected staff to ensure the residents' feet were on their wheelchair foot pedals when being pushed by staff. Administrative Nurse D said there should be a bag on the back of the wheelchair for the foot pedals to be stored in, in the event they are needed. Administrative Nurse D said she expected staff to ensure R11's call light was placed within her reach. The facility's policy Falls-Clinical Protocol documented if interventions had been successful in fall prevention, the staff would continue with current approaches and would discuss periodically with the physician whether the measures were still needed.

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	175451	A. Building B. Wing	01/08/2026

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F 0757 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure each resident?s drug regimen must be free from unnecessary drugs. The facility identified a census of 32 residents. The sample included 12 residents including five residents reviewed for unnecessary medications. Based on record review, interview and observation, the facility failed to monitor bowel movements for Resident (R) 2 and follow the physician orders to administer medications for constipation after a 13 day interval with no bowel movements documented. Findings included:- R2's Electronic Medical Records (EMR) documented diagnoses, which included constipation (difficulty passing stools) and pain due to acute trauma. R2's 12/17/25 admission Minimum Data Set (MDS) documented R2 had a Brief Interview for Mental Status (BIMS) score of 15, indicating intact cognition. The MDS noted R2 was frequently incontinent of bladder and bowels. R2 was dependent on the staff for care. The Urinary Incontinence and Indwelling Catheter Care Area Assessment (CAA) documented R2 was admitted from the hospital following a motor vehicle incident with multiple fractures. R2 had functional limited range of motion to her right arm and both legs. She needed maximum assistance with toileting, bathing, dressing, bed mobility, and transfer. She had frequent bowel and bladder incontinence. R2's Care Plan dated 12/23/25, documented R2 had pain related to multiple fractures and directed staff to monitor/document side effects of pain medication, which included constipation. R2's Physician Orders in the EMR documented a standing order for constipation- bowel protocol. Day one: prune or apple juice, or prunes in the morning and evening as needed for constipation, ordered 12/11/25.Standing orders for bowel protocol- Day two- Milk of Magnesia (laxative) 30 milliliters (ml) in the morning as needed for constipation, ordered 12/11/25. Standing orders for bowel protocol- Day three- Laxative suppository in the morning as needed for constipation, ordered 12/11/25. Review of R2's bowel movement frequency under the Tasks in the EMR dated 12/12/25 through 01/08/26 revealed the resident exceeded three days/72 hours without a bowel movement and/or treatment from 12/26/25 at 08:14 PM through 01/08/26 at 05:50 AM (13 consecutive days). R2's December 2025 and January 2026 Medication Administration Record (MAR) lacked evidence the Bowel protocol medications were administered as ordered. No medication for constipation was given, and no assessment was documented. R2's EMR lacked evidence of a clinical assessment related to the lack of bowel movements for the 13-day interval. On 01/06/26 at 10:23 AM, R2 laid in her bed. She reported she could not get out of bed due to her non-weight-bearing status. R2 stated it was difficult to even reposition in bed due to the fracture of her upper right arm. On 01/08/26 at 08:34 AM, Certified Nurse Aide (CNA) O stated the CNAs documented the bowel movements, and the nurses followed up if any medications were needed. On 01/08/26 at 09:29 AM, Licensed Nurse (LN) G stated an alert comes up in the EMR if the resident does not have a documented bowel movement in two days. She said she was unsure what the bowel protocol was; if needed, she would find out. LN G said staff followed up after day three of no bowel movement, and the nurse provided prune juice, then Milk of Magnesia on the following day if no bowel movement, then a suppository on the following day. On 12/03/25 at 11:07 AM, Administrative Nurse D said the nurse monitored the residents for bowel movement and followed the standing orders for the bowel movement protocol. If there was no bowel movement, the nurse assessed the resident, provided the proper medication, and documented the assessment and medication. If the resident took themselves to the bathroom, the CNAs were to ask the resident every shift if the resident had a bowel movement or not and document it. Administrative Nurse D stated if the system alerted more than three days with no bowel movement, and the nurse was unsure it was correct due to the resident taking herself to the bathroom, the nurse was to ask the resident if she had a bowel movement prior to giving medication and if the resident had a bowel movement, the nurse should document the bowel movement in the EMR. The facility did not provide a policy for bowel monitoring.

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. The facility had a census of 31 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to prevent significant medication errors for Resident (R) 2, R4, and R6, who did not receive medications as ordered. Findings included:1. R2's Electronic Medical Records (EMR) documented diagnoses which included constipation (difficulty passing stools), pain due to acute trauma, and multiple fractures, including to the face, both legs, right arm, and spine.R2's 12/17025 admission Minimum Data Set (MDS) documented R2 had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R2 was dependent on the staff for care. R2 took an anticoagulant (a class of medications used to prevent the blood from clotting) medication,The Functional Abilities (Self-Care and Mobility) Care Area Assessment (CAA) documented R2 was admitted from the hospital following a motor vehicle incident with multiple fractures and injuries. R2 had limited range of motion to her right arm and both legs. She needed maximum assistance with toileting, bathing, dressing, bed mobility, and transfer; standing was not attempted due to her non-weight-bearing status.R2's Care Plan dated 12/23/25, documented R2 had pain related to multiple fractures and directed staff to monitor/document side effects of pain medication, which included constipation. R2 had a self-care performance deficit related to multiple fractures with non-weight-bearing status, revised on 12/23/25. The plan lacked documentation of the anticoagulant medication.R2's Physicians Orders revealed an order for enoxaparin sodium (anticoagulant medication) injection solution, prefilled syringe 30 milligrams (mg)/per milliliter (ml) with instructions to inject the syringe two times a day related to long-term use of anticoagulants, ordered on 12/11/25.R2's Medication Administration Record, reviewed from 12/12/26 to 12/31/25 documented enoxaparin sodium was not given on 12/12/25 at 08:00 AM and 08:00 PM, 12/14/25 at 08:00 PM, 12/16/25 at 08:00 AM and 08:00 PM, 12/17/25 at 08:00 PM, 12/19/25 at 08:00 PM, 12/23/25 at 08:00 PM, 12/25/25 at 08:00 PM, 12/26/25 at 08:00 PM, 12/27/25 at 08:00 AM, 12/28/25 at 08:00 PM, 12/30/25 at 08:00 PM, and 12/31/25 at 08:00 PM.R2's Medication Administration Record, from 01/01/26 to 01/08/26, documented the enoxaparin sodium was not given on 01/02/26 at 08:00 PM, 01/03/26 at 08:00 PM, 01/05/26 at 08:00 AM, 01/05/26 at 08:00 PM, 01/08/26 at 08:00 AM.On 01/06/226 at 10:23 AM, R2 laid in her bed. She reported she could not get out of bed due to her non-weight-bearing status. 2. R4's EMR documented diagnoses which included obsessive-compulsive disorder (OCD- an anxiety disorder characterized by recurrent and persistent thoughts, ideas, and feelings of obsessions severe enough to cause marked distress, consume considerable time, or significantly interfere with the resident's occupational, social, or interpersonal functioning), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear).R4's 12/23/25 Significant Change MDS documented R4 had a BIMS of 15, indicating intact cognition. R4 took an antipsychotic (a class of medications used to treat major mental conditions which cause a break from reality) medication and an antidepressant (a class of medications used to treat mood disorders) medication.The Psychotropic Drug Use Care Area Assessment (CAA) documented R4 had a diagnosis of Alzheimer's disease, obsessive-compulsive disorder, and depression. R4 took bupropion (an antidepressant), fluoxetine (an antidepressant), and Risperdal (an antipsychotic).R4's Care Plan documented R4 had a history of verbal outbursts. She was started on Risperdal, and these behaviors have subsided, revised 07/10/25.R4's Physicians Orders revealed an order for Risperdal (risperidone) 0.5 milligrams, one tablet, two times a day, related to obsessive-compulsive disorder, ordered on 08/01/24R4's December 2025 Medication Administration Record documented Risperdal was not given on 12/15/25 at 08:00 PM, 12/21/25 at 08:00 PM, 12/23/25 at 08:00 PM, and 12/31/25 at 08:00 PM. 3. R6's EMR documented diagnoses, which included diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin),R6's 10/15/25 Quarterly MDS documented a BIMS could be completed, but it was not completed. R6 had a diagnosis of diabetes and received insulin (a hormone (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	which lowers the level of glucose in the blood) injections.R6's Care Plan documented R6 had a history of diabetes and was dependent on insulin, dated 05/07/25. The plan directed staff to monitor for signs and symptoms of high or low blood sugar,R6's Physicians Orders revealed the following orders:Novolog FlexPen 100 units/ml (fast-acting insulin), inject 15 units after meals related to diabetes, dated 12/10/25.Lantus (slow-acting insulin), inject 28 units at bedtime for diabetes, dated 04/29/25.R6's December 2025 Medication Administration Record documented Lantus was not given at 08:00 PM on 12/03/25, 12/11/25, 12/16/25, 12/19/25, and 12/22/25. The Novolog was not given at 06:00 PM on 12/11/25 or 12/22/25. The EMR lacked information on why it was not given.R6's January 2026 Medication Administration Record, documented on 01/02/26, Lantus was not given at 08:00 PM, and Novolog was not given at 07:00 PM. The BG at 04:00 PM was 140, and the BG at 08:00 PM was 140. The EMR lacked evidence of a hold order for the insulin. On 01/08/26 at 09:29 AM, Licensed Nurse (LN) G stated all medications should be given and documented as ordered and checked prior to leaving for the shift. On 01/08/26 at 10:29 AM, Administrative Nurse D said the nurse was to give medications and complete treatments when they are ordered and chart when they are completed. The pharmacist had been working with them on correcting the problem of medications not being given. On 01/08/26 at 08:40 AM, Licensed Nurse (LN) G stated if a medication was not given, staff should notify the provider, and it should also be documented in the chart as not given with a reason. LN G said if a medication was held, there should be a hold order and a progress note. On 01/08/26 at 8:45 AM, Administrative Nurse D stated if a medication was not given, the nurse should document it as not given, and if the medication was held, the nurse was to document it as held. Administrative Nurse D stated the nurse should notify the provider if a medication was held for any reason and there should be a hold order charted; the nurse should also make a progress note. Administrative Nurse D confirmed the medication errors. On 01/08/26 at 10:29 AM, Administrative Nurse D said the nurse should give medications and complete treatments when they were ordered and chart when they were completed. Administrative Nurse D said the pharmacist had been working with the facility on correcting the problem of medications not being given as ordered. The facility's undated Administering Medications policy stated medications shall be administered in a safe and timely manner as prescribed.

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. The facility reported a census of 31 residents. 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 actual hours worked, as required. Findings included:- Observed on 01/06/26 at 08:20 AM, the posted staffing sheet lacked the actual hours worked Observed on 01/07/26 at 09:30 AM, the posted staffing sheet lacked the actual hours worked. Observed on 01/08/26 at 10:30 AM, the posted staffing sheet lacked the actual hours worked. Review of the daily staffing sheets from 12/25/25 and 01/05/25 revealed the staffing sheets lacked the actual hours worked. During an interview on 01/08/26 at 08:20 AM, Administrative Nurse D stated the posted staffing sheet should have documented an accurate census, the total number of medical staff per shift, and should also have documented the actual hours and total hours worked. The facility policy Posting Direct Care Daily Staffing Numbers, dated 08/2022, documented the staffing sheet of staff who were directly responsible for resident care would be posted in a prominent location and in a clear and readable format. The policy also documented the posted document would include the name of the facility, current date, the resident census at the beginning of the shift for which the information was posted, the 24-hour shift schedule operated by the facility, the shift for which the information was posted, type and category of nursing staff working during the shift who were paid by the facility, the actual time worked during the shift for each category and type of nursing staff, and the total number of licensed and non-licensed nursing staff working for the posted shift.