STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175454	A. Building B. Wing	03/23/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Clearwater Nursing & Rehabilitation Center	620 E Wood Street Clearwater, KS 67026

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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 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 40 residents. The sample of seven residents included three residents reviewed for social/medically related social services. Based on observation, interview, and record review, the facility failed to provide care in a respectful and dignified manner for a dependent, cognitively impaired Resident (R)7 when staff shaved his beard off. Findings included:- R7's Electronic Health Record (EHR) documented diagnoses which included dementia (a progressive mental disorder characterized by failing memory and confusion) with psychotic (characterized by a gross impairment in reality and/or perception) disturbances, and failure to thrive. The 02/27/26 Entry Minimum Data Set (MDS) documented R7 admitted to the facility on [DATE]. R7's Discharge Return Anticipated MDS, dated 03/01/26, documented the resident was transferred to the hospital on [DATE]. R7's Baseline Care Plan, initiated on 02/27/28 and updated 02/28/26, informed staff that the resident had poor communication and comprehension. The plan did not address R7's preferences for maintaining and/or grooming his beard. R7's Progress Notes dated 02/27/26 at 07:16 PM, documented he arrived at the facility accompanied by his daughter, wife, and grandson. He was pleasantly confused and required total assistance from staff with hygiene care after having a bowel movement. A Progress Note dated 03/01/26 at 10:45 PM, documented the family spoke with a facility representative via phone regarding their desire to remove the resident from the facility related to the fall that occurred on 03/01/26. R7's family also voiced concerns and expressed that they were upset because facility staff shaved off R7's beard. The staff member informed R7's representative that the grievance would be addressed with the management team to follow up. The staff member documented notification the resident was being admitted to the hospital. Review of the facility Grievance Log revealed a grievance was filed on 03/10/26, nine days after the resident was sent to the hospital regarding the staff shaving R7's beard. The grievance report lacked an action plan and/or any follow-up with the family as of 03/24/26. On 03/24/26 at 11:26 AM, Certified Nurse Aide (CNA) N reported she did not recall the resident. The staff received training upon hire regarding resident rights and respecting resident/representatives' preferences. She stated she did not know who obtained the information, but would guess preferences should be obtained at admission from the resident and/or representative. CNA N said when a new resident admitted to the facility, the staff prepares the room and receives a report of the resident's needed and preferred care when they arrive. If a resident has dementia or is confused, then the family will usually give us information about what the resident likes and their routine prior to admission to make the resident's and family's transition easier. On 03/24/26 at 12:15 PM, Licensed Nurse (LN) G stated she did not recall the resident. She stated she was new and was not aware who obtained the information regarding preferences on admission, and said the facility should include the residents' and/or representative reports of the resident's past routines or preferences. On 03/24/26 at 03:35 PM, R7's representative stated R7's beard was part of his identity and all his friends and family knew him as having a beard. She stated his beard was rimmed and well-cared for. She stated when she arrived at the facility to visit her father, the facility had shaved his beard. She nearly walked past him because she did not even recognize him. Additionally, she (continued on next page)

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

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F 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	stated her children, the resident's grandchildren, did not recognize their grandfather. She said R7 had dementia and would not even recognize himself when he looked in the mirror. She stated she felt her father was stripped of his dignity and identity. She asked the staff why they had shaved him and was told that he had food in his beard. She stated the staff said they tried to call, but the number was wrong. R7's representative further stated she had discussed his beard being shaved with the Administrator and has not heard back from the Administrator or facility staff since filing a grievance. On 03/24/26 at 04:54 PM, Social Service X stated the resident and/or resident representative usually gave the facility the preference information for activities of daily living (ADLs), which should include shaving preferences, and if a resident was admitted with a full beard, that would be a nursing function. Social Service X stated she does not ask that question and did not know if consent would be required.to shave a resident with a full beard. She stated that if a grievance was reported, then it should be included on the Grievance Log and followed up by the appropriate department. She confirmed a grievance had been filed on 03/10/26 regarding the staff shaving R7 without contacting the family or representative, and said she expected staff to contact the representative before shaving off an existing beard for a resident with dementia. On 03/24/26 at 05:19 PM, Administrative Staff A confirmed the above findings. He stated the residents and/or representatives should be interviewed regarding the history of individual needs and preferences of the residents. He stated he expected that the information should be included in the development of the residents' care plan, and especially agreed that a resident with confusion should have input from their representative regarding their likes and dislikes related to the care and maintenance of their beard. He confirmed that a man with a beard, who has had a beard for years, may not be recognized by friends and/or family and could be unrecognizable without a beard if that is part of their identity. Administrative Staff A confirmed he had been made aware of the grievance regarding R7's beard being shaved on 03/10/26, and he had not responded to the reporter of the grievance as of 03/24/26. On 03/24/26 at 05:30 PM, Consultant GG agreed the R7 should not have had his beard shaved without consulting the resident's representative. She stated shaving a resident with dementia and a full beard without contacting the representative was not acceptable and would be upsetting to those who knew him as only having a beard as part of his identity. She verified the change in R7's appearance could be upsetting to family and friends who only knew him as having a beard. The undated facility policy titled Dementia Care Protocol documentation included the interdisciplinary team (IDT) would adjust interventions and the overall plan depending on the individual's responses to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in resident or family wishes, and other relevant factors.

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the appropriate treatment and services to a resident who displays or is diagnosed with dementia. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 40 residents. Based on observation, interview, and record review, the facility failed to provide supervision, treatment, services, and physical well-being for Resident (R) 2, who had dementia (a progressive mental disorder characterized by failing memory and confusion) with intrusive wandering behaviors by going into R6, R4, R3, and R5's rooms uninvited. Findings included:R2's Electronic Medical Record (EMR) documented diagnoses of dementia, hypertension (high blood pressure), and unspecified protein-calorie malnutrition. R2's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R2 had severe cognitive impairment, physical behavioral symptoms directed toward others, which occurred one to three days of the look back period, and wandered four to six days of the look back period. R2 used a wheelchair for mobility, was dependent with toileting, showering, and putting on and taking off footwear, required substantial/maximal assistance with upper and lower body dressing, lying to sitting on the side of the bed, chair/bed-to-chair transfers, and was dependent with sit-to -stand. Frequently incontinent of urine and always incontinent of bowel. The MDS further documented that R1 had a condition or chronic disease that may result in a life expectancy of less than six months, two or more noninjury falls, and was taking an antidepressant. The Behavioral Symptoms Care Area Assessment (CAA), dated 07/29/25, documented that R2 had a diagnosis of Alzheimer's disease, wandered, and had a wander guard in place. The CAA documented staff to redirect R1 as needed with cues and assistance. R2's Care Plan dated 01/16/26, documented that R2 had the potential to be physically aggressive related to dementia. The Care Plan directed staff to administer medications as ordered, monitor for side effects, assess and address contributing sensory deficits, assess the anticipated needs for food, thirst, toileting needs, comfort level, and body positioning. R2 tolerated small groups of people at a time and needed personal space when agitated. The Care Plan documented R2 triggers for physical aggression due to abrupt approaches and behaviors, which are de-escalated by distraction, redirection, and offering a snack. Document observed behavior and attempt intervention on the behavior log. When R2 becomes agitated, intervene before agitation escalates, guide away from the source of distress, and engage calmly in conversation. If the resident is aggressive, staff should walk calmly away and approach later. The Progress Note dated 02/15/26 at 02:50 PM, documented that the Registered Nurse (RN) was notified that R2 had been hit in the face by another resident. R2 was assessed for injuries. On 03/23/26 at 11:00 AM, R6 stated R2 had entered her room wearing only a diaper, and R6 had to tell him to get out. On 03/24/26 at 10:00 AM, R4 reported R2 would come into her room in a wheelchair, and she would get out of bed and push him out of the room to get R2 to leave. On 03/24/26 at 12:40 PM, R5 lay in bed with the bed in high position. R3 reported the bed in a high position so that R2 could not get into the bed, because R2 had tried to do so, and R2 does not always leave the room when told to leave. R5 also reported waking up at 05:00 AM, and R2 was touching her foot. On 03/24/26 at 09:00 AM, Certified Nurse Aide (CNA) M stated that when R2 went into another resident's room, staff assisted R2 out, directed R2 to follow staff out of the room, which was not R2's room, and provided fluids. On 03/24/26 at 09:04 AM, Licensed Nurse (LN) G reported R2 wandered, and usually stayed on one hall and the dining room, but when R2 went into another room, the staff would go in and take R2 out of the room. On 03/24/26 at 11:54 AM, R3 heard yelling for help. Therapy and other staff went to the room, and R2 was in the room. Staff redirected R2 out of the room. R3 stated she was all right, and R1 did not always leave when told to. On 03/24/26 at 11:54 AM, Certified Medication Aide (CMA) R reported trying to catch and redirect R2 when heading into other resident rooms. Staff offer snacks and soda. On 03/24/26 at 12:39 PM, Social Service X reported spending one-on-one time, talking, offering cookies, and having R2 assist with handing out papers. R2 would not stay at activities and on the go but could change from day to day. The facility's (continued on next page)

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F 0744 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	undated Dementia -Clinical Protocol policy documented that the staff and physicians will evaluate individuals with new or worsening cognitive impairment and behavior and differentiate dementia from other causes. The interdisciplinary team (IDT) will identify and document the resident's condition and level of support needed during care planning and review changing needs as they arise. The IDT will adjust interventions and the overall plan depending on the individual's response to those interventions, progression of dementia, development of new acute medical conditions or complications, changes in the resident's family wishes, and other relevant factors.

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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 40 residents. The sample included three residents reviewed for medications. Based on observation, record review, and interview, the facility failed to prevent significant medication errors for Resident (R) 1 who did not receive medications as ordered Additionally, the facility failed to notify the physician of the error. Findings included:- R1's Electronic Medical Records (EMR), documented diagnoses which included wound infection, osteomyelitis (local or generalized infection of the bone and bone marrow), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), renal failure (inability of the kidneys to excrete wastes, concentrate urine, and conserve electrolytes), and congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid). R1's 02/24/26 Medicare -5 Day Minimum Data Set (MDS) documented R1 had a Brief Interview for Mental Status (BIMS) of 15, indicating intact cognition. R1 had an infection of the foot and a diabetic ulcer. R1 took an antibiotic and intravenous (IV- administered directly into the bloodstream via a vein) medications. R1 had a diagnosis of a wound infection. R1's Care Plan dated 93/23/26, documented R1 had Methicillin-resistant Staphylococcus aureus (MRSA- a type of bacteria resistant to many antibiotics) in his right heel wound. The care plan directed staff to give antibiotic therapy as ordered. The Discharge Instructions dated 02/18/26 documented an order for Daptomycin Intravenous Solution Reconstituted (IV antibiotic) 500 milligrams (mg) intravenously and directed to see an outpatient antibiotic order. The Discharge Instructions dated 02/18/26 documented an order for Piperacillin Sod-Tazobactam So (an antibiotic) Solution Reconstituted 4 grams (g)-0.5 g/100 milliliter (ml). See the outpatient antibiotic order. R1's Preliminary Report documented an Infectious Disease (ID) Outpatient Antibiotic Order dated 02/17/26 for Daptomycin Intravenous Solution Reconstituted 750 mg intravenously every 48 hours until 03/14/26. Piperacillin Sod-Tazobactam Solution (IV antibiotic) Reconstituted 4.5 g intravenously two times a day for infection until 03/14/26. The report also documented a diagnosis of sepsis (a life-threatening systemic reaction that develops due to infections that cause inflammation throughout the entire body) likely due to a right heel wound, right heel necrotic (pertaining to the death of tissue in response to disease or injury) wound and palpable (a physical examination using touch) bone on a diabetic patient, and right leg wounds and cellulitis (skin infection caused by bacteria). The Preliminary Report documented an Infectious Disease (ID) Outpatient Antibiotic Order, which documented the antibiotic order above was for the first two weeks after dismissal from the hospital. Further antibiotic orders will be from ID clinic after the first appointment. R1's note from Infectious Disease Consultants, P.A dated 02/28/26 documented R1 went to an appointment on 02/28/26. At that time, the ID provider provided the staff the Final Report ID Outpatient Antibiotic Order dated 02/17/26. This order was different than the previous order, and the facility was directed to use the new order. Daptomycin Intravenous Solution Reconstituted 750 mg intravenously every 24 hours until 03/17/26. Piperacillin Sod-Tazobactam Solution Reconstituted 4.5 g intravenously every eight hours for infection until 03/17/26. R1's Electronic Medication Administration Record (EMAR) for February and March 2026 documented and ordered Piperacillin Sod-Tazobactam Solution Reconstituted 4.5 g intravenously two times a day for infection; started on 02/18/26. This order was not discontinued until 03/05/26 after R1 went to the hospital. R1's EMAR for February and March 2026 documented an order for Daptomycin Intravenous Solution Reconstituted 750 mg intravenously every 48 hours until for infection; started on 02/18/26. This order was not discontinued until 03/05/26 after R1 went to the hospital. R1's note from Infectious Disease Consultants, P.A documented he returned to the office for a follow-up visit on 03/05/26. At that time, the provider noted R1 did not receive the corrected medication frequency of either medication. The provider also noted the peripherally inserted central catheter (PICC-a thin, flexible tube that is inserted into a vein in the upper arm and threaded into a large vein above the heart) line dressing, which was to be changed weekly, and when needed, was loose and had not been changed since (continued on next page)

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	02/17/26. And the PICC line clave connector (sterilizable connector attached to the end of each lumen of a PICC line to allow for needle-free administration of fluids and medication. They are designed to prevent infection, often used with disinfecting caps, and typically changed weekly using sterile technique, involving clamping the lumen and scrubbing the hub.) The doctor was notified, and the PICC line was taken out because it had been exposed for an unknown amount of time, and the patient is at a high risk for developing a central line-associated bloodstream infection. R1 was sent to the hospital for worsening wounds and concern for blood infection. On 03/23/26 at 08:52 AM, R1 sat in his wheelchair beside his bed watching television. Licensed Nurse (LN) G entered the room and washed her hands. LN G donned her gloves and opened the flush. R1 wore a long-sleeved tight shirt, so the dressing could not be visualized. R1's sleeve could be pushed up to expose the end of the PICC lumen. LN G cleaned the Clave connector with an alcohol pad and flushed the port with normal saline. LN G obtained the IV line and attached it to the Clave. LN G checked the IV bag and programmed the IV pump to run for one hour. On 03/23/26 at 02:44 PM, LN G stated when a resident returned from an appointment, the nurse should look at the information from the provider and change the orders as needed. On 03/23/26 at 02:53 PM, Administrative Nurse D stated the charge nurse on duty should have updated the order when R1 returned from the appointment. Administrative Nurse D said she has reeducated the nurses that this is the expectation and started calling ID weekly to prevent any future problems. The facility's undated policy, Medication and Treatment Orders, documented medications will be consistent with principles of safe and effective order writing.