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	06/03/2026

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 0689 Level of Harm - Immediate jeopardy to resident health or safety 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** Based on record review, observation, and interview, the facility failed to provide adequate supervision to prevent an elopement for cognitively impaired Resident (R)14, who the facility identified as at high risk for wandering. On 05/15/2026 at approximately 11:35 AM, R14 exited the unsecured smoking area in the facility parking lot after Certified Nurse Aide (CNA) M turned to assist another resident. At approximately 01:43 PM, Dietary Staff BB went to R14's room to pick up his lunch tray and identified that the resident was not in his room and had not eaten lunch. Dietary Staff BB notified other staff, and they began searching for R14 at 01:45 PM. At approximately 02:04 PM, staff located R14 approximately 0.8 miles from the facility and returned him to the facility without injuries. The weather outside at that time ranged from 82 degrees to 88 degrees Fahrenheit (F). While R14's actual route was unknown, the resident would have crossed multiple busy [NAME] streets and railroad tracks to reach his destination. The facility failed to ensure R14 received adequate supervision to prevent an elopement, which placed R14 in immediate jeopardy. Findings included:- R14's Electronic Medical Record (EMR) documented he had diagnoses of hallucinations (sensing things while awake that appear to be real, but the mind created), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), schizophrenia (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R14's Quarterly Minimum Data Set (MDS) dated [DATE] documented R14 had a Brief Interview for Mental Status (BIMS) score of eight, which indicated moderate cognitive impairment. The MDS documented R14 had no behaviors or wandering during the observation period. R14's Care Plan prior to the elopement noted R14 was able to ambulate in a wheelchair by self-propelling, and staff were to encourage use of the wheelchair due to R14's amputation (surgical removal) of his toes. Staff frequently observed R14 ambulating without his wheelchair, and his weight bearing status was unrestricted, initiated: 06/05/2025 and revised on 02/21/2026. R14's Care Plan noted R14 was an elopement risk/wanderer due to a history of attempts to leave the facility unattended, initiated and revised on 09/26/2025. The plan, dated 09/26/2025, instructed staff to distract the resident from wandering by offering pleasant diversions, structured activities, food, conversation, television, book. The section called Resident prefers: had nothing else listed. Another intervention, dated 09/26/2025, documented R14 had a WanderGuard applied to his wrist. R14's Elopement Care Plan, dated 05/22/2026, after the elopement, documented R14 was an elopement/risk due to history of attempts to leave the building. The care plan directed staff to distract R14 from wandering by offering pleasant diversions, structured activities, food, conversion, television, or books. The care plan documented R14 had a WanderGuard (a bracelet that helps monitor residents who are at risk of wandering) applied to his wrist. R14's Elopement Risk Assessment dated 03/26/26 documented a score of 18, indicating a high risk. A Communication with Family/NOK/POA note dated 05/15/26 documented the resident walked away from the facility while out on a smoke break with staff. Upon 14's return to the facility (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

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	at 02:20 PM, staff performed a full head to toe assessment, and no trauma was noted. R14 had no complaints and denied any pain at the time. A ?Health Status Note dated 05/15/26 documented that upon R14's return to the facility, he was drinking a bottle of water. Staff performed a head-to-toe assessment, and no trauma was noted. The resident stated that he was hungry, and a sandwich and chips were given to him, along with a glass of water. The resident denied any pain. His face was red. The resident was taken into the dining room after he finished his sandwich and chips because he was still hungry. The resident ate some more food and then wanted to go to his room. Staff walked the resident to his room, where he laid down in his bed. The Facility Incident Report, documented on 05/15/26 at approximately 01:35 PM, CNA Q noted R14 was not at the nurse's station for a smoke break. CNA Q went to get R14, but he was not in his room. Around the same time, Certified Medication Aide (CMA) S went to give R14 his medication and noted he was not in his room. R14 usually received a room tray for lunch, and staff provided a room tray. Dietary Staff BB went to pick up R14's room tray at approximately 01:43 PM and noted the resident was not in his room and his food was untouched. Dietary Staff BB notified Administrative Nurse B at 01:43 PM, and staff initiated the Missing Resident Protocol. Administrative Nurse B notified Administrative Nurse D and Administrative Staff A. Multiple staff went to search outside at 01:45 PM. After searching (walking) the property, three staff members began driving around to look for R14. At the same time, Administrative Nurse D reviewed the cameras and noted that R14 went out for a smoke break with staff at approximately 11:35 AM. R14 was in the designated smoking area, which was in the parking lot, with other residents and CNA M. There were eight other residents in the smoking area during this time, and five of the eight residents needed supervision with smoking, while four other residents were independent with smoking. Two of the residents were cognitively impaired residents who required Wander Guards. R14 began walking towards the dietary door at 11:34 AM. CNA M turned her back to assist another resident and R14 continued walking through the parking lot towards the front door. He arrived at the front door at 11:35 AM and was seen on camera walking past the front door and heading west toward the church parking lot. At approximately 02:04 PM, he was located approximately 0.8 miles from the facility and transported back to the facility at approximately 02:10 PM. CNA M's Notarized Witness Statement, dated 05/15/26, documented that during a smoke break, R14 walked toward the door to be let inside, and CNA M pulled another resident backwards toward to the door. When CNA M got to the door, R14 was gone, and she thought someone had let him back inside. CNA M documented after staff realized R14 was not on the property, staff looked for him outside and eventually found him. CMA S's Notarized Witness Statement, dated 05/15/26, documented when she was passing medication around 01:35 PM, she went to R14's room to give him his medications, but he was not there. She asked the other aides where R14 might be and they responded, in his room. CMA S stated she informed them R14 was not in his room, and one of the other aides stated he might be down Hall 3 taking a nap. One of the CNA staff went down to look for him while another informed the charge nurse. CMA S documented the last time she observed R14 was around 10:30 to 11:00 AM at the smoke break before lunch. On 06/01/26 at 02:45 PM, observation revealed R14 ambulated down the 300 hall with a walker, dressed in street clothes to the activity room. Continued observation revealed R14 pushed on the exit door that led to the patio/gazabo area where the residents smoked (scheduled smoke break was scheduled for 03:00 PM). R14 pushed the door and after 15 seconds, the door lock released, and the door opened, which sounded an alarm. Staff responded and redirected R14 back inside, away from the door to wait until the 03:00 PM smoke break that was supervised by staff. On 06/01/26 at approximately 03:45 PM, observation of the area where R14 exited the facility revealed multiple busy [NAME] roads around and between the facility and the area where the resident was found had posted speeds up to 45 miles per hour (mph). Observation further revealed railroad tracks between the facility and the area where R14 was located. In an interview on 06/01/26 at 03:50 PM, CNA M stated she took the residents out for a smoke break, and when it was time to go in, she saw R14 walk toward the door to be let inside. She said she was pulling another resident backwards to the door, and (continued on next page)

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F 0689 Level of Harm - Immediate jeopardy to resident health or safety Residents Affected - Few	when she got up to the door, R14 was gone and no longer outside. She said she thought he was let inside and went to lunch. In an interview on 06/01/26 at 03:45 PM, Dietary Staff CC said he was in his office eating his lunch when staff told him that they could not find R14. He said he did not have his truck, so his coworker gave him the keys to her car, and he went looking for him. Staff told him they saw on the camera R14 heading north. They went down one street with posted speeds of 35 mph, went over the railroad tracks, and saw R14 walking toward the local C0-op. He pulled down a little dirt driveway and asked R14 if he needed a ride, and R14 said he needed a ride to Wichita. Dietary Staff CC called other staff to where the resident was, and they loaded R14 into the car. Dietary Staff CC stated it was very hot outside, so when he got back, staff gave him fluids and food. On 06/01/26 at 01:45 PM, Administrative Nurse D stated the facility video camera footage revealed R14 was last seen on 05/15/26 at 11:34 AM outside in the parking lot /designated smoking area and was visualized on camera. She stated the camera revealed R14 exited from the unalarmed, unsecured smoking area. She said staff delivered a room tray to the resident's room at some point, but no one noticed the resident was missing until dietary staff went to pick up his room tray at 01:43 PM. Administrative Nurse D verified the resident was found at 02:04 PM and was transported back to the facility, with no injuries noted. Administrative Nurse D verified the resident had an elopement risk with cognitive impairment and should not have been unattended when he was outside. Administrative Nurse D verified the facility changed the location of the smoking area to the outdoor patio/gazabo area that was secured with a fence and exit doors that alarmed, and the resident continued to be monitored during smoke breaks. The facility's Wandering and Elopement policy, dated March 2025, documented the facility would identify residents who are at risk of unsafe wandering and strive to prevent harm while maintaining the least restrictive environment for residents. If identified at risk for wandering, elopement, or other safety issues, the resident's care plan would include strategies and interventions to maintain the resident's safety. If an employee observes a resident leave the premises, he/she should. a. Attempt to prevent the residents from leaving in a courteous manner. b. get help from other staff members in the immediate vicinity, if necessary; and c. instructs another staff member to inform the charge nurse or director of nursing that a resident is attempting to leave. If a resident is missing, initiate the elopement/missing resident emergency procedure. a. Determine if the resident is out on an authorized leave or pass, b. If the resident was not authorized to leave, initiate a search of the building and premises; and c. If the resident is not located, notify the administrator, the director of nursing services, the resident's legal representative, the attending physician, law enforcement officials, and as necessary, volunteer agencies like emergency management, rescue squads, etc.) When the resident returns to the facility, the director of nursing or charge nurse shall: a. Examine the resident for injuries. b. Contact the attending physician and report findings and conditions of the resident. c. Notify the resident's legal representative (sponsor). d. Notify the search teams that the resident has been located:e. Complete and file incident report; and f. Document relevant information in the resident's medical record. On 06/02/26 at 03:23 PM, Administrative Staff A and Administrative Nurse D received the Immediate Jeopardy [IJ] Template and were notified of the facility's failure to provide adequate supervision to prevent an elopement for R14 placed the resident in immediate jeopardy. The facility identified and implemented immediate corrective actions completed by 05/16/26, which included all staff in-service on meal protocols, smoking supervision and safety, and supervision of all residents. All residents had a new elopement assessment completed on 05/15/26. An elopement drill was conducted on 05/15/26 for the 06:00 PM- 06:00 AM, and 05/17/26 for the 06:00 AM-06:00 PM shift. The smoking area was moved to a secure courtyard on 05/15/26. All residents who smoked had an updated smoking assessment. All residents with Wander Guards were checked for functionality. Staff completed a trauma assessment for R14. Dietary began using the reconciliation form for each meal. Due to all corrective actions being completed before the onsite survey, the citation was deemed past noncompliance and existed at a J (isolated, immediate jeopardy) scope and severity.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. Based on record review and interview, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. Findings included:- Review of the Registered Nursing Staffing Schedule for March 2026, April 2026, and May 2026 revealed the facility lacked a Registered Nurse on the following dates:03/16/26,03/21/26 and 03/22/26.04/04/26 and 04/18/26.05/02/26, 05/03/26, 05/16/26, 05/23/26, 05/24/26 and 05/31/26. On 06/03/26 at 09:00 AM, Administrative Nurse D verified the facility did not have a Registered Nurse in the building for eight consecutive hours or working as a charge nurse for the above documented dates. The facility's Registered Nurse policy, dated January 2024, documented the facility would employ the services of an RN for at least eight consecutive hours a day, seven days a week. The facility would designate an RN to serve as the Director of Nursing (DON) on a full-time basis. The policy documented the DON may serve as a charge nurse only when the facility has an average daily census of 60 or fewer residents. The RN hours would be recorded and reported on staffing sheet and would be reported on the Payroll Based Journal (PBJ) reporting system. Per Facility Assessment, the facility may identify when the residents of the facility require the services of an RN for more than eight hours a day based on the acuity level of the resident population, The facility may choose a variety of hours of duty such as an eight hour or a twelve hour shift, but the facility would always ensure eight consecutive hours of RN service every day, seven days per week.

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F 0730 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Observe each nurse aide's job performance and give regular training. Based on record review and interview, the facility failed to provide regular in-service education based on the outcome of performance reviews and failed to ensure all nurse aides received the required number of in-service training hours per year. This placed the residents at risk of impaired care. Findings Include:- The facility's employment records documented eleven nurse aides were employed at the facility for at least one year. The facility's in-service records documented that 5 of those nurses' aides reviewed had not completed the required 12 hours of in-service training in the past year.Certified Nurse Aide (CNA) N, hired 01/29/2024, lacked the required number of in-service hours and in-services based on performance evaluations. CNA O, hired 05/29/2025, lacked the required number of in-service hours and in-services based on performance evaluations.CNA P, hired 05/22/2025, lacked the required number of in-service hours and in-services based on performance evaluations.CNA Q, hired 02/24/2025, lacked the required number of in-service hours and in-services based on performance evaluations.Social Service Director (SSD) and CNA X, hired 10/13/2023, lacked the required number of in-service hours and in-service based on performance evaluations. On 06/03/25 at 09:30 AM, Administrative Nurse D stated she had been employed at the facility for approximately six weeks and was unable to find the documentation and failed to provide the hours needed by the nurse aide staff. The In-Service Training Program, Nurse Aide,, dated May 2021, documented all nurse aides would participate in regularly scheduled in-service training classes. The facility completes a performance review of nurse aides at least every 12 months. In-service training is based on the outcome of the annual performance reviews, addressing weaknesses. Annual in-services:Ensure the continuing competencies of nurse aides.Are no less than 2 hours per employment year. Address areas of weakness as determined by the facility assessment.Addresses the special needs of the residents, as determined by the facility assessment.Include training that addresses the care of residents with cognitive impairment: and Include training in dementia management and abuse prevention. All in-service classes attended by the employee are entered on the prospective employee's Record of In-Service by the department supervisor or other persons as designated by the supervisor

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F 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, interview, and record review, the facility failed to employ a full-time certified dietary manager for the 32 residents who resided in the facility and received meals from the facility kitchen. Findings included:- On 06/02/2026, a review of the noon meal consisted of pork loin, oven-roasted potatoes, carrots, and Jello parfait.On 06/02/2026 at 11:00 AM, observation revealed Dietary CC in the kitchen overseeing the preparation of the noon meal.On 06/01/2026 at 08:00 AM, Dietary CC stated he was not a Certified Dietary Manager (CDM) and had not been enrolled in any dietary certification classes.On 06/03/26 at 09:00 AM, Administrative Nurse D verified he was not certified and planned to enroll him in classes at the end of June.The facility's Food and Nutrition Services policy, dated 10/2021, documented the Food Services manager would be CDM certified or enrolled in an accredited CDM program and on pace for completion.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. Based on observation, interview, and record review, the facility failed to store, prepare, distribute, and serve food by professional standards for food service safety, and failed to consistently document food temperatures, refrigerator and freezer temperatures, and the dish machine PPM (Parts Per Million-a unit of measure used to indicate the concentration of a chemical sanitizer in the wash or rinse water) sanitizer log. Findings included:- On 06/01/2026 at 08:00 AM, during the initial kitchen tour, the stove had dried food and a greasy substance down the side and front, and inside the oven door, layers of black, stuck-on crusty food substances. The burners on the stove had blackened food particles. The shelf with the pots and pans had dried food particles throughout the shelf. The walk-in freezer had several unbagged tater tot potatoes and other unknown food items on the floor. The microwave in the dining room was dirty on the inside, with dried orange colored substance stuck on the top and food particles on the bottom and sides. Under two of the sinks, a hand sink and a food preparation sink, were containers of dirty water from the pipes that had leaked.On 06/01/2026 at 08:15 AM, a review of the dining room refrigerator temperature log for May 2026 lacked documentation. The temperature was not taken during the following days:05/12/2026- Evening 05/20/2026- Evening05/21/2026- Morning and Evening05/22/2026- Morning and Evening05/23/2026- Evening 05/24/2026- Morning05/25/2026- Morning05/26/2026- Morning and Evening05/27/2026- Morning05/28/2026- Morning and Evening05/29/2026- Morning and Evening05/30/2026- Morning and Evening05/31/2026- Morning and EveningReview of the walk-in refrigerator temperature log for May 2026 lacked documentation. The temperature was not taken during the following days:05/14/2026- Evening 05/15/2026- Evening 05/16/2026- Morning and Evening05/172026- Morning and Evening05/18/2026- Morning and Evening05/19/2026- Evening 05/20/2026- Evening 05/21/5026- Evening 05/23/2026- Evening 05/24/2026- Morning and Evening05/25/2026- Morning05/27/2026- Evening 05/28/2026- Evening 05/29/2026- Morning and Evening05/30/2026- Morning and Evening05/31/2026- Morning and EveningReview of the walk-in freezer temperature log for May 2026 lacked documentation. The temperature was not taken during the following days:05/14/2026- Evening 05/15/2026- Morning and Evening05/16/2026- Morning and Evening05/172026- Morning and Evening05/18/2026- Morning and Evening05/19/2026- Evening 05/20/2026- Evening 05/21/5026- Evening 05/23/2026- Evening 05/24/2026- Morning and Evening05/25/2026- Morning05/27/2026- Evening 05/28/2026- Evening 05/29/2026- Morning and Evening05/30/2026- Morning and Evening05/31/2026- Morning and EveningOn 06/01/2026 at 08:15 AM, Dietary CC was asked for the daily meal temperature logs for May 2026. Dietary CC was unable to produce any of the logs except for five days in the month of May. Dietary CC was asked for the daily dish machine PPM sanitizer record log, and he was unable to provide any recent log. Dietary CC stated he had only been here for six weeks and had new staff. Dietary CC stated he was aware that the kitchen was not as clean as it should be. He stated it was everyone's responsibility to clean the kitchen. He stated he had talked with the administration to see if there was a day that they could cater in meals so that they could do a deep clean in the kitchen. Dietary CC further stated he would make sure staff were documenting temperatures for the food, refrigerators, and freezers.On 06/02/2026 at 11:30 AM, Dietary DD stated she used the precision chlorine test strips daily for the sanitizer. Observation revealed the test strips had expired in 05/2026.On 06/03/2026 at 09:33 AM, Maintenance U stated he was aware the pipes had leaked under the sink and had plans to fix them this week.The facility's Food Preparation and Service policy, dated 10/2021, documented that the temperatures of food held in steam tables are monitored throughout the meal by food and nutrition services staff. Food and nutrition services employees prepare and serve food in a manner that complies with safe food handling practices.The facility's Refrigerator and Freezers policy, dated 10/2021, documented that the facility would ensure safe refrigerator and freezer maintenance, temperatures, and sanitation, and would observe food (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	expiration guidelines. Monthly tracking sheets for all refrigerators and freezers would be posted to record temperatures. Food Service Supervisors or designated employees would check the refrigerator and freezer temperatures daily upon first opening and at closing in the evening. Refrigerators and freezers would be kept clean, free of debris, and mopped with sanitizing solution on a scheduled basis and more often as necessary.

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F 0809 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure meals and snacks are served at times in accordance with resident?s needs, preferences, and requests. Suitable and nourishing alternative meals and snacks must be provided for residents who want to eat at non-traditional times or outside of scheduled meal times. Based on interview, and record review, the facility failed to consistently provide a nourishing evening snack to the 33 residents, who resided in the facility, 11 of whom have diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). Findings included:- On 06/02/2026 at 11:00 AM, during the resident council meeting, Resident (R) 18 and R22, stated they were diabetic and did not always have snacks available at night. They stated that they used to have them at the nurse's station, but some residents were taking too many, and others would not receive one. Both residents stated there were no sandwiches available if they wanted one, just apples, bananas, fig bars, and cheese crackers.On 06/02/2026 at 1130 AM, Dietary CC stated that he was working on a better selection of snacks for the residents during the evening. Dietary CC stated that right now, he had Jell-O, pudding, and Cheetos that residents could have. He wanted to get a cabinet that they could lock up snacks that only staff could hand out. Dietary CC further stated that he planned to provide different sandwiches for the residents and verified that he had not consistently provided protein snacks for the residents with DM. He stated that residents can ask for sandwiches when dietary staff are in the building, and before dietary staff leave the building, the staff are given the evening snacks for the residents.On 06/02/2026 at 02:15 PM, Licensed Nurse (LN) G stated that dietary staff bring the evening snacks, which are kept in a container underneath the nurses' station and are given to residents if they ask.On 06/03/2026 at 09:00 AM, Administrative Nurse D stated there were residents who would take a bunch of the snacks, and it did not leave enough for other residents. Some residents had asked for grilled cheese sandwiches late at night, and the dietary staff was already gone for the night. Dietary CC was working on a plan to make sure there were enough sandwiches and snacks for all the residents, and they planned to put a lock on a cabinet and a lock on the refrigerator for the cold items, like different sandwiches.The facility's Food and Nutrition Services policy, dated 10/2021, documented nourishing snacks are available to the residents 24 hours a day. The residents may request snacks as desired, or snacks may be scheduled between meals to accommodate the residents' typical eating patterns.

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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 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a plan that describes the process for conducting QAPI and QAA activities. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure their (QAA) Quality Assessment and Assurance Committee adequately identified deficient areas of practice and develop and implement appropriate plans of action to correct the deficient practices for the 68 residents residing in the facility. Findings included:- Based on observation, record review, and interview, the facility failed to post the results of the most recent survey in a place readily accessible to residents, family members, and legal representatives of residents. Refer to F577. Based on observation, record review, and interview, the facility failed to provide a resident with written information regarding the facility's bed hold policy when they were transferred to the hospital. Refer to 628. Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan with instructions to staff on providing surgical wound cares for a resident. Refer to 656. Based on observation and record review, the facility failed to apply the standards of practice when staff intentionally documented that they had provided treatments to a resident though they had not actually provided the treatments. Refer to 658. Based on observation, record review and interview, the facility failed to apply the standards of practice as related to dependent edema when staff failed to wrap a resident's legs to decrease the edema (swelling resulting from an excessive accumulation of fluid in the body tissue) in his legs as ordered. Refer to 684. Based on observation, record review, and interview, the facility failed to provide adequate resident supervision for elopement. Refer to 689. Based on observation, record review, and interview, the facility failed to provide infection control practices with a resident who had a nebulizer and oxygen tubing that was left on the bed and not stored properly. Refer to 695. Based on observation, record review, and interview, the facility failed to ensure staff possessed the skills and competencies required when administering insulin to a resident. Refer to 726 Based on observation, record review, and interview, the facility failed to use the services of a Registered Nurse (RN) for at least eight consecutive hours a day, seven days a week. Refer to 727 Based on observation, record review, and interview, the facility failed to provide regular in-service education based on the outcome of performance reviews and failed to ensure all nurse aides receive the required number of in-service training hours per year. Refer to 730. Based on observation, record review, and interview, the facility failed to label insulin when opened and when expired and failed to discard expired insulin pens. Refer to 761. Based on observation, record review, and interview, the facility failed to employ a certified Dietary Manager. Refer to 801. Based on observation, record review, and interview, the facility failed to consistently provide a nourishing evening snack. Refer to 809. Based on observation, record review, and interview, the facility failed to store, prepare and serve in the kitchen. Refer to 812. Based on observation, record review, and interview, the facility failed to follow the infection control program, lacked donning and doffing of personal protective equipment in an isolation room, and failed to properly clean an isolation room. Refer to 880. On [DATE] at 1:30 PM, Administrative Staff A stated the QAA meetings were held monthly and included the medical director. The facility's QAPI Plan, dated [DATE], documented the QAPI program would aim for safety and high quality with all clinical interventions and services delivered while emphasizing autonomy, choices, and quality of daily life for residents and family by ensuring the data collection tools and monitoring systems are in place and are consistent for proactive analysis, system failure analysis, and corrective action. The facility would utilize the best available evidence, national benchmarks, published best practices, and clinical guidelines to define and ensure the facility goals. The plan documented at least annually or as needed, the QAPI Self-Assessment would be conducted. The assessment would be completed with the input from the entire QAPI team and organizational leadership. The result of the assessment would direct the facility to areas that needed to be worked on in order to establish and improve QAPI programs and processes in the organization. The annual facility assessment would be conducted to identify gaps in care and service delivery in order to (continued on next page)

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	provide necessary services. The items would be considered in the development and implementation of the QAPI plan.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to provide Resident (R) 22, with written information regarding the facility's bed hold policy when they were transferred to the hospital. Findings included: - The Electronic Medical Record (EMR) for R22 documented diagnoses of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin,) cerebral infarction (stroke - sudden death of brain cells due to lack of oxygen caused by impaired blood flow to the brain by blockage or rupture of an artery to the brain,) chronic respiratory failure (a long-term condition where the respiratory system struggles to adequately exchange oxygen and carbon dioxide, leading to dangerous low oxygen or high carbon dioxide levels in the blood,) hypoxemia (abnormal deficiency in the concentration of oxygen in arterial blood,) and syncope (fainting or passing out). R22's Quarterly Minimum Data Set (MDS), dated [DATE], documented R22 had a Brief Interview for Mental Status (BIMS) score of 14, which indicated intact cognition. R22 was dependent upon staff assistance for toileting hygiene, personal hygiene, and to shower/bathe herself. R22's Care Plan, dated 06/03/25, directed staff to monitor and report any signs or symptoms of coronary artery disease, chest pain or pressure, especially with activity, heartburn, nausea and vomiting, shortness of breath, and excessive sweating due to R22's altered cardiovascular status. R22's Progress Notes dated 02/07/26 at 12:44 PM, documented R22 complained of chest pain and shortness of air. R22 was alert and oriented. Staff obtained vital signs, and her blood pressure was 147/98 millimeters (mm) of mercury (Hg) and her pulse was 111 beats per minute. Emergency Medical Services transported R22 to the hospital for further evaluation and treatment. R22's Progress Notes dated 02/07/26 at 04:46 PM, documented R22 was admitted to the hospital for observation. R22's clinical record lacked evidence that a copy of the bed hold policy was provided to the resident or representative when she was transferred to the hospital. On 06/01/26 at 11:10 AM, observation revealed R22 lying in bed. On 06/02/26 at 10:00 AM, Administrative Nurse D verified R22 did not have a bed hold in her records and stated they should have had a bed hold notice provided to R22 and her responsible party. The facility's Bed Hold policy undated, documented before the facility transfers a resident to the hospital the resident goes or therapeutic leave, the facility would provide written information to the resident and/or resident representative that specifies the duration of the state bed-hold policy during which the resident is permitted to return and resume residency in the facility. The reserve bed payment policy in the state plan; the facility's policies regarding bed-hold period, which are consistent with the law permitting the resident to return. All information provided to a resident and/or representative requires a signature of receipt of the policy by the resident and/or representative, including bed hold information provided at the time of admission and bed hold information provided at the time of discharge/transfer related to hospitalization and/or therapeutic leave.

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F 0656 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop and implement a complete care plan that meets all the resident's needs, with timetables and actions that can be measured. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to develop a comprehensive care plan with instructions to staff on providing surgical wound cares for Resident (R) 46. Findings included:- R34's Electronic Medical Record (EMR) documented he had a diagnosis of mastoiditis (serious bacterial infection of the skull just behind and below the ear). R34's admission Minimum Data Set (MDS), dated [DATE], documented R34 as a Brief Interview of Mental Status (BIMS) of 15, which indicated intact cognition. The MDS documented R34 required supervision with most activities of daily living (ADLs). The MDS documented that the resident had surgical wounds and received surgical wound care. The Care Area Assessment, CAA, dated 05/04/26, documented Resident triggered for potential skin breakdown d/t supervision needed to maintain ADL function. Surgical wound care and had a diagnosis of osteomyelitis (local or generalized infection of the bone and bone marrow)R34's Care Plan, revised 05/20/26, acknowledged information regarding the resident's surgical wounds. The plan lacked instructions to staff on how to care for R34's surgical wounds.On 06/03/26 at 02:00 PM, observation revealed R34 sat in a wheelchair in the therapy room with a dressing on the top of his head and behind his left ear.The Nurse's Note, dated 04/29/26, documented R34 admitted to the facility from the hospital. He had removal of squamous cell carcinoma (slow-growing type of cancer) a few months ago with flap and skin graft failure. R34 was then brought back to the hospital for debridement (medical removal of dead, damaged, or infected tissue to improve the healing potential for the remaining healthy tissue) of the scalp wound and closure with split-thickness skin graft (part of skin implanted to cover areas where skin was lost through burns or injury) and muscular cutaneous flap (surgical reconstructive technique that transfers a block of tissue consisting of an underlying muscle, its overlying skin, and the fat between them. He had also developed osteomyelitis and mastoiditis. On 06/02/26 at 09:25 AM, Licensed Nurse (LN) G verified that the skin integrity section of the care plan lacked interventions or instructions for staff on how to care for his wounds. LN G stated she goes by R34's care instructions on the Treatment Administration Record (TAR). LN G stated that if an agency nurse worked at the facility, she could see how the nurse would not know how to care for R34's wounds by looking at his care plan.On 06/02/26 at 01:00 PM, Administrative Nurse E verified R34's verified R34's skin integrity section in his care plan lacked instructions to staff on how to care for his surgical wounds, and they should be on it.

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on observation, record review, and interview, the facility failed to apply the standards of practice when staff intentionally documented that they had provided treatments to Resident (R) 39, though they had not actually provided the treatments. Findings included:- R39's Electronic Medical Record (EMR) documented diagnoses of edema, heart failure (a condition with low heart output and the body becomes congested with fluid), and urinary retention (lack of ability to urinate and empty the bladder). The Quarterly MDS, dated 03/19/2026, documented R39 had intact cognition. R39 was independent in toileting, personal hygiene, and mobility. The MDS further documented R39 had lower functional impairment on both sides, required supervision with transfers, and received diuretic medication daily. R39's 04/14/2026 Care Plan included the following interventions for R39: 10/23/2025- Inspect R39's skin daily with cares, administer medications as ordered, monitor and report any pertinent laboratory results to the physician, monitor vital signs as ordered, and notify the physician of any abnormalities. Monitor, document, and report as needed any signs of dependent edema in the legs and feet. The care plan lacked direction to the staff regarding wrapping his legs with Ace wraps (a stretchable cloth wrap designed to provide localized pressure, reduce swelling, and support weak or injured muscles and joints) or that R39 refused the wraps. The Physician Order, dated 12/08/2025, directed staff to apply Ace wraps up to mid-thigh (the section of the lower limb that extends between the hip and the knee) in the morning and remove at bedtime. The Treatment Administration Record, dated June 2026, documented that staff applied the Ace wraps on the following days:06/01/202606/02/2026 On 06/01/2026 at 10:21 AM, R39 had on gripper socks and did not have on the Ace wraps as ordered. R39 stated that he was to have his legs wrapped every day, but that it rarely happened unless he reminded them to do it. On 06/01/2026 at 03:00 PM, R39 had on gripper socks and did not have on the Ace wraps as ordered. On 06/02/2026 at 01:50 PM, R39 had on gripper socks and did not have on the Ace wraps as ordered. On 06/02/2026 at 02:13 PM, Licensed Nurse (LN) G stated that staff tried to get R39 to wear the wraps every day, but he would refuse. LN G stated that she had charted that she had applied the Ace write the last two days and verified that R39 had not had them on. LN G asked if she should go in and change the charting, then said she would go to R39 and offer to put on the Ace wraps. On 06/03/2026 at 09:00 AM, Administrative Nurse D stated that if R39 did not want the Ace wraps, staff are to document that he refused and should not document that they were applied when they were not. The facility's Quality of Care policy, dated 10/2021, documented that the facility was committed to providing high-quality care and services to residents in a safe, respectful, and person-centered environment. The facility staff members would be highly trained, qualified, and dedicated to providing compassionate care.

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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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to apply the standards of practice as related to dependent edema when staff failed to wrap Resident (R) 39's legs to decrease the edema (swelling resulting from an excessive accumulation of fluid in the body tissue) in his legs as ordered. Findings included:- R39's Electronic Medical Record (EMR) documented diagnoses of edema, heart failure (a condition with low heart output and the body becomes congested with fluid), and urinary retention (lack of ability to urinate and empty the bladder).R39's admission Minimum Data Set (MDS), dated [DATE], documented R39 had intact cognition. R39 was independent with toileting hygiene, personal hygiene, transfers, and mobility. The MDS further documented R39 had lower functional impairment on both sides and received diuretic (a medication to promote the formation and excretion of urine) medication daily.The Quarterly MDS, dated 03/19/2026, documented R39 had intact cognition. R39 was independent in toileting, personal hygiene, and mobility. The MDS further documented R39 had lower functional impairment on both sides, required supervision with transfers, and received diuretic medication daily.R39's 04/14/2026 Care Plan included the following interventions for R39:10/23/2025- Inspect R39's skin daily with cares, administer medications as ordered, monitor and report any pertinent laboratory results to the physician, monitor vital signs as ordered, and notify the physician of any abnormalities. Monitor, document, and report as needed any signs of dependent edema in the legs and feet. The care plan lacked direction to the staff regarding wrapping his legs with Ace wraps (a stretchable cloth wrap designed to provide localized pressure, reduce swelling, and support weak or injured muscles and joints) or that R39 refused the wraps.The Physician Order, dated 09/27/2025, directed staff to administer spironolactone (a diuretic medication), 50 milligrams (m), by mouth, daily for edema.The Physician Order, dated 12/08/2025, directed staff to apply Ace wraps up to mid-thigh (the section of the lower limb that extends between the hip and the knee) in the morning and remove at bedtime.The Treatment Administration Record, dated May 2025, documented that staff applied the Ace wraps on the following days:05/01/202605/06/202605/11/202605/20/202605/21/202605/25/2026The Nurse's Notes for the above dates documented that R39 did not have the wraps when they went to remove them or that R39 had refused them.The Treatment Administration Record, dated June 2026, documented that staff applied the Ace wraps on the following days:06/01/202606/02/2026On 06/01/26 at 10:21 AM, R39 had on gripper socks and did not have on the Ace wraps as ordered. R39 stated that he was to have his legs wrapped every day, but that it rarely happened unless he reminded them to do it.On 06/01/26 at 03:00 PM, R39 had on gripper socks and did not have on the Ace wraps as ordered.On 06/02/26 at 01:50 PM, R39 had on gripper socks and did not have on the Ace wraps as ordered.On 06/02/2026 at 02:13 PM, Licensed Nurse (LN) G stated that staff tried to get R39 to wear the wraps every day, but he would refuse. LN G stated that she had charted that she had applied the Ace write the last two days and verified that R39 had not had them on. LN G asked if she should go in and change the charting, then said she would go to R39 and offer to put on the Ace wraps.On 06/03/2026 at 09:00 AM, Administrative Nurse D stated that if R39 did not want the Ace wraps, staff are to document that he refused and should not document that they were applied when they weren't.The facility's Quality of Care policy, dated 10/2021, documented that the facility was committed to providing high-quality care and services to residents in a safe, respectful, and person-centered environment. The facility ensured all residents received the highest standard of care, promoting each resident's physical, emotional, social, and psychosocial well-being and aiding in fostering a culture of continuous improvement and helping guide staff to deliver exceptional care to all residents.

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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, record review, and interview, the facility failed to provide infection control practices for Resident (R)16, when staff left her nebulizer mouthpiece (a device that changes liquid medication into a mist easily inhaled into the lungs) on the bed and left her BIPAP (-Bilevel Positive Airway Pressure is a noninvasive ventilation device that helps patients breathe by delivering two levels of air pressure: higher during inhalation and lower during exhalation) tubing, that was unattached from the oxygen concentrator (medical device that separates nitrogen from the air around you so you can breathe up to 95% pure oxygen), directly on the floor. Findings included:- R16's Electronic Medical Record (EMR) documented diagnoses of chronic obstructive pulmonary disease (COPD-a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing) and pleural effusion (abnormal accumulation of fluid in the lungs).The Quarterly Minimum Data Set (MDS), dated [DATE], documented R16 had intact cognition. R16 was dependent upon staff for all activities of daily living. R16 had shortness of breath (SOB) with exertion, at rest, and when lying flat. R16 required the use of oxygen therapy and used a non-invasive mechanical ventilator daily.R16's 05/13/2026 Care Plan included the following interventions for R16:11/03/2025- Assist R16, family, and caregivers in learning signs of respiratory compromise, encourage sustained deep breaths, and ask her to yawn, maintain a clear airway by encouraging her to clear her own secretions with effective coughing. Monitor and document changes in orientation, increased restlessness, anxiety, and air hunger. Monitor her breath patterns and report any abnormalities to the physician, position her with proper body alignment for optimal breathing patterns, and administer medication as ordered. R16's care plan directed staff to ensure her Bipap settings as ordered and was on continuous oxygen at 3 liters (L) per nasal cannula (a lightweight, flexible medical device used to deliver supplemental oxygen directly into the nostrils).The Physician's Order, dated 03/16/26, directed staff to administer 1 ipratropium-albuterol solution (a sterile inhalation solution), 0.5-2.5 (3) milligram (mg)/3 milliliter (ml) nebulizer treatment every four hours for SOB.On 06/01/2026 at 10:16 AM, R16's nebulizer mouthpiece was lying on the bed next to her. R16's BIPAP tubing was disconnected from the oxygen concentrator and was lying on the floor unbagged.On 06/02/2026 at 09:15 AM, R16's nebulizer mouthpiece was lying on the bed next to her. R16's BIPAP tubing was disconnected from the oxygen concentrator and was lying on the floor unbagged.On 06/03/2026 at 07:00 AM, R16's nebulizer mouthpiece was lying on the bed next to her. R16's BIPAP tubing was disconnected from the oxygen concentrator and was lying on the floor unbagged.On 06/02/2026 at 09:00 AM, Certified Medication Aide (CMA) R verified the tubing should be in the bags provided.On 06/03/2026 at 07:30 AM, Administrative Nurse D stated the tubing from the BiPAP should be placed in the bag that was on the oxygen concentrator. Administrative Nurse D further stated R16 liked to have the nebulizer mouthpiece lying next to her on the bed and stated she would make sure that R16's preferences were on the care plan.The facility's Administration of Oxygen undated policy, documented staff are to store all nebulizer masks and tubing in labeled and dated plastic bags.

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F 0726 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that nurses and nurse aides have the appropriate competencies to care for every resident in a way that maximizes each resident's well being. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure staff possessed the skills and competencies required when Licensed Nurse (LN) G failed to prime a Humalog (rapid-acting hormone that lowers the level of glucose in your blood) Kwik Pen (a pre-filled, disposable insulin injection device). prior to administration to Resident (R)19. Findings included:- On 06/02/2026 at 10:13 AM, R19 ambulated in the hall with a walker. LN G asked R19 if she was ready to receive her insulin, and R19 replied yes and entered her room. LN G followed her in with a plastic container that held a Humalog, 100 UNIT/milliliter (ml) [NAME] Pen, LN G clicked up seven units of insulin in the pen, then, without priming the pen (a procedure which removes the air from the needle and cartridge that may collect during normal use, ensuring that the pen is working correctly), administered the insulin in R19's left arm. LN G verified she had not primed the insulin and stated she was unaware she was supposed to. Upon request, the facility was unable to provide LN G's nursing skills check sheet.Review of a blank nursing skills check: medication pass check sheet revealed a lack of competency assessment regarding priming an insulin Kwik Pen. The Insulin Kwik Pen Instructions Pamphlet instructed staff to prime an insulin Kwik Pen before each injection. Priming your pen means. the pamphlet documented to prime a pen, turn the dose knob to select 2 units, hold your pen with the needle pointing up, tap the cartridge holder gently to collect air bubbles at the top, continue holding your pen with the needle pointing up, push the dose know in until it stops, and 0 is seen in the dose window. Hold the dose in and count to 5 slowly. You should see insulin at the tip of the needle. If you do not see insulin, repeat priming steps no more than 4 times. If you still do not see insulin, change the needle and repeat priming steps 6 to 8 times. On 06/03/2026 at 08:51 AM, Administrative Nurse D stated she expected staff to prime the insulin pen with two units of insulin before administering it to a resident. Administrative Nurse D stated that upon hire, nurses had to perform a competency check-off on insulin. On 06/03/26 at 09:50 AM, Administrative Nurse D verified that the nursing skills check lacked a competency check regarding priming an insulin kwikpen. Administrative Nurse D stated she could not find LN G's nursing skills check sheet. The facility's Competency of Nursing Staff Policy, undated, documented that the facility and resident -specific competency evaluations would be conducted upon hire, annually, and deemed necessary based on the facility assessment. All nursing staff must meet the specific competency requirements of their respective licensure and certification requirements defined by state law.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to label Resident (R)6 insulin (a hormone that lowers the level of glucose in the blood) flex pens when initially opened for use and when expired and failed to discard R43's insulin flex pen that had expired. This deficient practice placed the affected residents at risk for ineffective medications. Findings included:- On [DATE] at 08:30 AM, observation of the facility's treatment cart revealed the following:R6's Humalog (fast-acting insulin) FlexPen was not labeled with an open date or an expired date.R43's Lantus (long-acting insulin) flex pen was labeled with an opened date of [DATE] and an expired date of [DATE]. On [DATE] at 08:15 AM, Administrative Nurse D verified the nurses should label and date the insulin flex pens with the date opened and discard the expired insulin flex pens. Medlineplus.gov directs open, unrefrigerated Humalog and Lantus can be used within 28 days; after that time, they must be discarded. The facility's Administering Medications policy, dated [DATE], documented medications are administered in a safe and timely manner, and as prescribed. The expiration/beyond use date on the medication label is checked prior to administering. When opening a multi dose container, the date is recorded on the container. Insulin pens containing multi dose of insulin are for single-resident use only. Insulin pens are clearly labeled with the resident's name or other identifying information. Prior to administering insulin with an insulin pen, the nurse verifies the correct pen is used for that resident. The expiration beyond use date on the medication label is checked prior to administering. When opening a multi-use container, the date is recorded on the container.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to ensure a sanitary and comfortable environment to help prevent the development and transmission of communicable diseases and infections when staff failed to change gloves and wash hands during incontinence care for Resident (R) 42. Staff also failed to store R12's breathing treatment mask and tubing in a sanitary manner. Findings included:1. On 06/01/26 at 10:00 AM, observation revealed R42 rested in bed on his back. Certified Nurse Aide (CNA) N and CNA O donned a gown and applied gloves and entered R42's room. R42 reported to the CNAs that he needed incontinence care due to having a bowel movement. CNA O gathered supplies, while CNA N pulled down the resident's pants and instructed him to turn onto his left side. Further observation revealed CNA N pulled down the brief in the back to reveal a moderate amount of stool covering the backside and his wound dressing area. CNA N removed the brief and dressing and provided peri-care to R42's buttock area, then instructed R42 to turn on his back. Further observation revealed CNA O provided peri-care to the residents' front peri area (private area) with the same soiled gloves, and then wearing the same gloves, placed a new incontinent brief underneath the resident and fastened it. The CNAs then removed and discarded the gloves. Observation revealed that both CNAs applied new gloves and assisted R42 in pulling up his pants, then doffed their gowns with gloves, placed them in a plastic bag, CNA O tied the bag, and both CNAs left the resident's room without washing their hands or using hand sanitizer. On 06/01/26 at 10:20 AM, CNA N verified that she had not changed gloves or washed her hands after providing incontinent care for R42 and stated that she usually washes her hands when entering another resident's room to provide care. 2. On 06/02/26 at 10:14 AM, observation revealed R12's breathing machine mask and tubing lying on the floor by a recliner, on top of a blue cloth bag, uncovered. Licensed Nurse (LN) G verified the finding and asked R12 where the plastic bag was for the mask and tubing, and the resident did not answer. LN G laid the uncovered mask on top of an end table, stated she would get a bag and take care of the mask and tubing, and left the room. On 06/03/26 at 08:51 AM, Administrative Nurse D stated she expected staff to store a resident's breathing treatment, a mask, and tubing in a bag. Administrative Nurse D stated she would expect staff to change gloves when providing incontinent care after dirty, and before they place a new incontinent brief on, and staff should wash their hands before and after providing care. The facility's Administration of Oxygen Policy, undated, instructed staff to store equipment in a dated plastic bag and leave it at the bedside.The facility's Handwashing/Hand Hygiene Policy, undated, instructed staff to use an alcohol-based hand rub containing at least 62% alcohol; alternatively, soap (antimicrobial or non-antimicrobial) and water for the following situations:Before and after coming on duty.B. Before and after direct contact with residents.Before preparing or handling medications.Before performing a non-surgical invasive procedure.Before performing a non-surgical invasive procedure.Before donning sterile gloves.Before handling clean or soiled dressings, gauze pads, etc.Before moving from a contaminated body site to a clean body site during resident care.After contact with a resident's intact skin.After contact with blood or bodily fluids.After handling used dressings, contaminated equipment, etc.After contact with objects (medical equipment) in the immediate vicinity of the resident.After removing gloves.Before and after entering isolation precautions settings

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	06/03/2026

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

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 0577 Level of Harm - Potential for minimal harm Residents Affected - Many	Allow residents to easily view the nursing home's survey results and communicate with advocate agencies. Based on observation, record review, and interviews, the facility failed to post the results of the most recent surveys in a place readily accessible to residents, family members, and legal representatives of residents. Findings included:- On 06/01/26 and 06/02/26, observation revealed the facility lacked a readily accessible posting regarding where the most recent survey results could be found.On 06/02/26 at 12:20 PM, when asked where the most recent survey was, Nurse Consultant CC found the most recent survey in a black binder located on the front reception desk without a sign notifying residents, family members, and representatives where the results were located. Nurse Consultant CC stated the facility should have a sign to indicate where the survey results were located so residents, family members, or residents' representatives could view them.The facility's Survey Results, Examination of Policy, revised October 2021, documented copies of survey results are maintained in the administrative office. A copy of the most recent standard survey, including any subsequent extended surveys, follow-up revisits reports, etc., along with state-approved plans of correction of noted deficiencies, would be maintained in a three-ring binder located in an area frequented by most residents, such as the main lobby or resident activity room.