STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175472	A. Building B. Wing	01/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Hillside Village of DE Soto Rehabilitation and Nur	33600 West 85th Street DE Soto, KS 66018

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 43 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store and prepare food in a sanitary manner for the residents who reside in the facility and receive meals from the facility kitchenette. Findings included: - On 01/05/26 at 12:30 PM, during lunch meal service observation of the facility's kitchenette revealed a two-door refrigerator/freezer which had storage of one box of frozen vanilla Magic Cup (nutritional supplement that contained additional calories and protein), four ounces (pack of 48) with an expiration date of 10/16/25. Further observation revealed four Magic Cups had been removed from the box. On 01/06/26 at 12:35 PM, Dietary Staff BB verified the expiration date of 10/16/25. Dietary Staff BB stated the distributor had delivered the box to the facility on [DATE] and verified the date stamped on the side of the box, which indicated the date the product was shipped from the distributor. Dietary Staff BB verified the product had expired and should be discarded, and further verified staff should look at the expiration date when the product was stocked in the kitchenette. On 01/07/26 at 11:30 AM, during a tour of the medication room, observation revealed in the refrigerator 95 vanilla Magic cups, four ounces, with an expiration date of 10/11/25. On 01/07/26 at 11:40 AM, Administrative Nurse D verified the expiration date of 10/11/25 and stated they would discard the expired cups. The facility's General Food Handling/Storage/Preparation policy, dated 2021, documented the facility would provide safe and sanitary storage, handling, and consumption of all food including food and fluids brought to residents by family and other visitors The facility procures food from sources approved or considered satisfactory by federal, state or local authorities, which includes the storage, preparation, distribution, and serving food in accordance with professional standards for food safety. Effective food safety systems involved for identifying hazards at specific points during food handling and preparation, and identifying how hazards can be prevented, reduced, or eliminated. It is important to focus attention on the risks that are associated with foodborne illnesses by identifying critical control points in the food preparation process that, if not controlled, might result in food safety hazards are thawing, cooking, cooling, handling, and reheating of foods, and employee hygiene practices. Facility staff would follow applicable State and local laws or regulations with respect to obtaining food items directly from local producers. The facility would purchase food from approved vendors, inspect all products on delivery, cover, label, and date refrigerated items, and indicate an expiration date for all items.

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

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

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility had a census of 43 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to maintain a Quality Assessment and Assurance Committee (QA&A) that had the required membership in attendance. Findings included: - Upon review of the facility's QA&A committee attendance signed roster for the monthly meetings held 01/27/25 through 12/17/25, the roster of attendance lacked the signature of the Medical Director, except for 08/29/25. On 01/06/25 at 11:31 AM, Administrative Staff A reported the Medical Director had only signed one of the monthly meeting rosters. Administrator Staff A stated they would be working on scheduling QA&A meetings quarterly with the Medical Director present. The facility's Quality Assurance and Performance Improvement policy, dated 04/2025, documented the facility would establish and implement a Quality /assessment and assurance/committee, develop a written Quality Assurance and Performance Improvement Plan, which would be used to continually assess the facility's performance using a systematic, interdisciplinary, comprehensive, and data-driven approach to maintaining and improving safety and quality. The QAA committee would include the Director of Nursing, Medical Director, Administrator, Infection Preventionist, and at least two other members. The committee would meet at least quarterly or more often as the facility deemed necessary.

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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 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** The facility had a census of 43 residents. The sample included 12 residents. Based on interview and record review, the facility failed to notify the State Long Term Care Ombudsman (LTCO) of Resident (R) 1, R3, R20, and R45's facility-initiated discharge to the hospital. Findings included: - R1's Electronic Medical Record (EMR) included diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), atrial fibrillation (rapid, irregular heartbeat), chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder, dementia (a progressive mental disorder characterized by failing memory and confusion), paranoid schizophrenia (mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought), sleep disorder, and diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin). R1's Minimum Data Set (MDS) dated [DATE] and 10/02/25, documented that R1 had been discharged and return anticipated. R1's Quarterly MDS dated 12/18/25 documented the resident had moderately impaired cognition, used a wheelchair for mobility, was dependent on staff for toileting hygiene, lower body dressing, and required partial to moderate assistance with personal hygiene, rolling in bed, and transfers. The MDS further documented that R1 received an antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality), antidepressant (a class of medications used to treat mood disorders), antiplatelet (a class of medication that prevents blood from clumping and clotting), and anticonvulsant (medications used to prevent convulsions-seizure (violent involuntary series of contractions of a group of muscles). The Progress Note dated 09/06/25 at 02:00 PM documented at 12:10 PM, R1 had complained about not feeling well, had difficulty sitting on the edge of the bed, was nauseated, and was diaphoretic (sweating heavily). R1 had drowsiness but open eyes to verbal and tactile stimulation. The provider was notified and ordered to send R1 to the hospital for evaluation. The Progress Note dated 09/16/25 at 02:00 PM documented that R1 had returned from the hospital after having a decreased mental status. The Progress Note dated 10/02/25 at 02:58 PM documented that R1 had a seizure (violent, involuntary series of contractions of a group of muscles). The staff notified the practitioner and obtained orders to send R1 to the hospital. The Progress Note dated 10/08/25 at 11:49 AM documented that R1 had returned from the hospital. On 01/06/26 at 07:45 AM, R1 was sitting in the dining room in a wheelchair, waiting for breakfast. R1 was dressed and groomed appropriately for the day. On 01/06/25 at 01:30 PM, Social Services X reported the information pulled from the monthly discharges to notify the Ombudsman State Agency lacked R1's discharges to the hospital. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 01/06/25 at 03:45 PM, Administrative Nurse D stated she was uncertain of the requirements of the Ombudsman notification and that Social Services was responsible for this. The facility's Criteria for Transfer and Discharge policy, dated 04/2025, documented that when the facility transfers or discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institution or provider. The facility shall send information of notice of discharge to the State Long-Term Care Ombudsman. - R3's Electronic Medical Record (EMR) included diagnoses of peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin) with foot ulcer, acquired absence of right leg above the knee, congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), non-pressure chronic ulcer of left foot with necrosis (localized tissue death that occurred in a group of cells in response to disease or injury) of muscle, major depressive disorder (major mood disorder that causes persistent feelings of sadness), and atherosclerotic heart disease (plaque buildup in artery walls). R3's Minimum Data Sheet (MDS) dated [DATE] recorded a discharge return anticipated. The Quarterly MDS dated 11/11/25 documented R3 had mild cognitive impairment, required substantial to maximal assistance with upper body dressing, showering, rolling in bed, and was dependent on staff for lower body dressing and transfers. The MDS further documented that R3 had a diabetic foot ulcer, pressure reducing device for the chair, nutrition or hydration interventions to manage skin problems, and application of ointment/medication and dressing to the feet. R3's Care Plan dated 11/21/25 documented R3 had atherosclerotic heart disease and instructed staff to monitor for acute onset of shortness of breath, pleuritic (sharp stabbing chest pain with deep breathing) chest pain, cough, syncope (fainting or passing out), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The Progress Note dated 09/07/25 at 05:59 PM documented that R3 continued to receive an antibiotic (class of medication to treat infections) for pneumonia (infection in the lungs). The Progress Note dated 09/10/25 at 03:43 PM documented R3 and the family wanted the resident to go to the hospital due to extreme fatigue and not feeling better. The staff notified the practitioner. The Progress Note dated 09/16/25 at 10:06 AM documented R3 and been admitted to the hospital on [DATE], due to pneumonia, and returned to the facility on [DATE]. On 01/06/26 at 08:03 AM, R3 self-propelled in her wheelchair to the dining room. On 01/06/25 at 01:30 PM, Social Services X reported that the information pulled from the monthly discharges to notify the Ombudsman State Agency lacked R3's discharges to the hospital. On 01/06/25 at 03:45 PM, Administrative Nurse D stated she was uncertain of the requirements of the Ombudsman notification and that Social Services was responsible for this. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Criteria for Transfer and Discharge policy, dated 04/2025, documented that when the facility transfers or discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving healthcare institution or provider. The facility shall send information of notice of discharge to the State Long-Term Care Ombudsman. - R20's Electronic Medical Record (EMR) revealed diagnoses of atherosclerotic heart disease (plaque buildup in and on arterial walls), chronic respiratory failure (a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), asthma (a disorder of narrowed airways that causes wheezing and shortness of breath), and hypoxia (inadequate supply of oxygen). R20's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R20 had moderate cognitive impairment (problems with thinking, learning, remembering, and using judgment). The MDS recorded she required staff assistance with transfers and activities of daily living (ADL). The MDS documented the resident required oxygen therapy and ambulated with a walker and wheelchair. The Care Area Assessment (CAA) dated 08/01/25 recorded R20 required staff assistance with ADLs due to impaired functional ability. The CAA documented the resident had cognitive loss. R20's Care Plan dated 12/31/25 recorded R20 required staff assistance with most ADL care. R20's Care Plan documented the resident required oxygen therapy due to respiratory failure. The care plan documented staff would monitor the resident for respiratory distress and report to the physician as needed, and monitor oxygen saturation as ordered. On 11/13/25 at 10:01 AM Nurse's Notes documented R20 had abnormal vital signs: blood pressure 89/52 (normal 120/80), pulse 52 (normal 60-100 beats per minute), respirations 16 normal (12-20 breaths per minute), and oxygen saturation 92% (normal 95-100 percent) with oxygen per nasal cannula. The nurse's note documented the resident had grayish-tinted skin, cool to the touch, unable to arouse, right side fascial drooping, and slurred speech. The nurse practitioner was notified and ordered to send R20 to the emergency room. On 11/13/25 at 02:50 PM Nurse's Notes documented the facility called the hospital and stated R20 was admitted to the hospital for stroke-like symptoms. On 11/15/25 at 06:54 PM Nurse's Notes documented the resident was admitted back to the facility at 04:50 PM, per medical transport in a wheelchair, accompanied by her relative. R20 had oxygen on per nasal cannula, could verbalize needs, and denied pain or discomfort. R20's clinical record lacked documentation staff notified the LTCO of R20's discharge from the facility. On 01/06/26 at 01:30 PM, Social Service X stated they send a notification of residents discharged from the facility to the Ombudsman regarding the location they discharged to monthly. Social Service X verified she did not send the R20's discharge to the Ombudsman's monthly discharge report due to her program did not identify Medicare residents to be on the report. Social Service X verified she was able to edit the computer program and record the Medicaid residents discharged , and would send the Ombudsman the past months discharges she had failed to send. (continued on next page)

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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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Admission, Discharge, and Transfer policy, dated 04/2025, documented when the facility transfers and discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institute or provider. The policy documented the facility shall send a copy of the notice to the State Long Term Care Ombudsman. - R45's Electronic Medical Record (EMR) revealed diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), atrial fibrillation (rapid, irregular heartbeat), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), chronic kidney disease (long term where the kidneys cat filter blood [NAME], causing waste buildup, and lead to complications like heart disease, anemia, and potentially kidney failure), quadriplegic (inability to move the arms, legs, and trunk of the body below the level of an associated injury to the spinal cord), and weakness. R45's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R45 had intact cognition and required staff assistance with transfers and activities of daily living (ADL). The MDS documented the resident ambulated with a wheelchair and received insulin (a hormone that lowers the level of glucose in the blood) and scheduled pain medication due to the spinal cord injury. The Care Area Assessment (CAA) dated 04/02/25 recorded R45 required staff assistance with ADLs due to recent hospitalization for a spinal cord injury and quadriplegia. R45's Care Plan dated 12/18/25 recorded R45 required staff assistance with ADL care. R45's Care Plan documented the resident required pain relief due to a recent spinal cord injury and was on antibiotics (medication that fights infections by killing bacteria or stopping them from multiplying) due to a lower leg wound infection. The Care Plan documented staff would monitor the resident for nausea, diarrhea, hypersensitivity, and allergic reaction from medications. On 12/28/25 at 11:59 AM Nurse's Notes documented R45's nurse practitioner requested to send the resident to the hospital due to recent abnormal labs to evaluate and treat. The nurse practitioner informed the resident of the possible outcome if he would not be treated for the abnormal lab values. On 12/28/25 hospital History and Physical documented R45 went to the hospital due to abnormal labs, hyponatremia (a dangerous condition where blood sodium levels drop below 135 milliequivalents per liter), cellulitis of the bilateral lower legs, and malaise (vague, uneasy feeling of body weakness, distress, or discomfort). On 12/30/25 at 04:00 PM Nurse's Notes documented the resident was admitted back to the facility, per medical transport. R45 was awake and sitting in a wheelchair in his room with the call light within reach. R45's clinical record lacked documentation staff notified the LTCO of R45's discharge from the facility. On 01/06/26 at 01:30 PM, Social Service X stated they sent notification of residents discharged from the facility to the Ombudsman regarding the location they discharged to monthly. Social Service X verified she did not send the R45's discharge to the Ombudsman's monthly discharge report due to her program did not identify Medicare residents to be on the report. Social Service X verified she was able (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	to edit the computer program and record the Medicaid residents discharged , and would send the Ombudsman the past months' discharges she had failed to send. The facility's Admission, Discharge, and Transfer policy, dated 04/2025, documented when the facility transfers and discharges a resident, the facility shall ensure that the transfer or discharge is documented in the resident's medical record and appropriate information is communicated to the receiving health care institute or provider. The policy documented the facility shall send a copy of the notice to the State Long Term Care Ombudsman.

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F 0755 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide pharmaceutical services to meet the needs of each resident and employ or obtain the services of a licensed pharmacist. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 43 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to administer Resident (R) 6's medication as prescribed and instructed. Findings included: - R6's Electronic Medical Record (EMR) included diagnoses of hypothyroidism (a condition characterized by decreased activity of the thyroid gland), gastroesophageal reflux disease (GERD- backflow of stomach contents to the esophagus), unspecified severe protein-calorie malnutrition, dysphagia (swallowing difficulty), muscle weakness, need for assistance with personal care, and vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain). R6's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R6 had severe cognitive impairment, used a wheelchair for mobility, and required partial to moderate assistance with toileting, upper and lower body dressing, rolling in bed, and transfers. The MDS further documented that R6 received an antianxiety (a class of medications that calm and relax people), antidepressant (a class of medications used to treat mood disorders), anticoagulant (a class of medications used to prevent the blood from clotting), and a diuretic (a medication to promote the formation and excretion of urine). R6's Care Plan dated 12/31/25 documented that R6 received anticoagulant, diuretic, antidepressant, antianxiety, and had a nutritional problem. The Care Plan directed staff to administer medications as ordered and to monitor for side effects. The Care Plan lacked instructions related to the use of medication for hypothyroidism, and gastroesophageal medication or conditions. The Physician Order dated 09/22/25 instructed staff to administer Levothyroxine (medication used to treat thyroid conditions) 100 milligrams (mcg) by mouth one time a day, on an empty stomach, for hypothyroidism (a condition characterized by decreased activity of the thyroid gland). The Physician Order dated 09/22/25 instructed staff to administer Omeprazole (medication used to treat gastric reflux conditions) 40 mg by mouth two times a day, for GERD. The Physician Order dated 12/29/25 instructed staff to administer Ferrous Sulfate (medication used to treat anemia) 325 mg by mouth in the morning for anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to body tissues) and to not administer with Omeprazole or Levothyroxine. On 01/06/25 at 07:48 AM, Certified Medication Aide (CMA) R prepared medications for the administration of R6. CMA R reviewed the Electronic Medication Administration Record (EMAR). CMA R provided all the morning medications, including the Ferrous Sulfate, Levothyroxine, and Omeprazole, crushed together and mixed in yogurt, at the same time. R6 took them without difficulty. On 01/06/25 at 12:00 PM, CMA R reviewed the EMAR and verified the instructions directing staff not to administer the Ferrous Sulfate with Omeprazole or Levothyroxine. CMA R verified that she gave all the medications at the same time, but had overlooked the instructions when she administered R6's medications earlier that morning. On 01/06/25 at 02:35 PM, Administrative Nurse D verified CMA R should have followed the physician's order for R6 and should not have administered the Ferrous Sulfate with Omeprazole and Levothyroxine. The facility's Medication Administration General Guidelines policy, dated 08/2014, documented medications were administered only by licensed nursing, medical, pharmacy, or other personnel authorized by state laws and regulations to administer medications. Medications were administered in accordance with written orders of the prescriber.

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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. The facility had a census of 43 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to implement acceptable infection control practices when staff failed to properly store Resident (R) 14's oxygen tubing and nasal cannula (a device used to deliver supplemental oxygen or increased airflow to a person in need of respiratory help) in a sanitary manner. Findings include: - On 01/05/26 at 10:45 AM, observation revealed R14's unbagged oxygen tubing and nasal cannula draped over the handle of her wheelchair, attached to the oxygen cannister behind the wheelchair. On 01/06/26 at 07:45 AM, observation revealed R14's unbagged oxygen tubing and nasal cannula draped over the handle of her wheelchair, attached to the oxygen cannister behind the wheelchair, and the nasal cannula was approximately 10 inches from the floor. On 01/06/26 at 04:10 PM, Administrative Nurse D stated the oxygen tubing and cannulas should be stored in a bag when not in use, and she would have an in-service to remind the staff of appropriate storage. The facility's Oxygen Storage policy, dated 01/2022, documented the facility would maintain all oxygen equipment in a clean and sanitary manner and to ensure humidifiers, tubing, masks, and cannulas for residents receiving oxygen. The equipment would be discarded after use by the resident, and the facility would maintain clam tanks, connectors, and concentrators. The policy documented when masks or cannulas were temporarily not being used, they would be stored in a plastic bag.