STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175473	A. Building B. Wing	06/10/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
The Nicol Home	303 E Buffalo St Glasco, KS 67445

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 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. Based on observation, record review, and interview, the facility failed to provide a written notice for a transfer for Resident (R)5, R7, and R26 (or their representatives) when they were transferred to the hospital or the bed hold policy. The facility also failed to complete a discharge summary with a recapitulation (a concise medical document required during discharge from a long-term care facility or nursing home. It summarizes the resident's course of treatment, diagnoses, and medical progress) of R33's stay when R33 was discharged from the facility. Findings included:- R7's Nurse's Note, dated 04/25/2025 at 02:50 PM, documented the resident admitted to the hospital.R7's clinical record lacked evidence that the resident or representative was provided with a written notification of transfer, or a copy of the bed hold policy. Upon request, the facility was unable to provide evidence.2. R5's Nurse's Note, dated 01/23/2026 at 08:35 PM, documented R5 admitted to the hospital for observation and urinary tract infection (UTI-an infection in any part of the urinary system).R5's Nurse's Note, dated 02/08/202026 at 09:42 PM, documented R5 admitted to the hospital for a UTI.R5's clinical record lacked evidence that the family received written notification of the transfer or a copy of the bed hold policy for the transfers on 01/23/26 and 02/08/2026. Upon request, the facility was unable to provide evidence.3. R26's Nurse's Note, dated 05/14/2026 at 06:12 PM, documented R26 admitted to the hospital for kidney failure.R26's clinical record lacked evidence that the resident or representative was provided with a written notification of transfer or a copy of the bed hold policy. Upon request, the facility was unable to provide evidence.4. R33's Nurse's Note, dated 04/29/2026 at 09:45 AM, documented R33 transferred to another facility.R33's Discharge Summary, dated 04/29/2026 at 09:45 AM, documented that the resident was discharged to another facility to be closer to the spouse. Report was given to the nurse at the receiving facility, and vital signs were checked. The summary documented R33 was alert and oriented to person and place, required extensive assistance with most activities of daily living (ADLs). R 33 had multiple scabbed areas on the extremities and a pressure area on the right buttocks, with a dressing change done. R33 continued to have a urinary catheter (a tube inserted into the bladder to drain the urine into a collection bag) with cloudy yellow urine and required a lot of encouragement to drink fluids to try and prevent UTIs. All belongings were sent with the family at the time of discharge. The summary lacked a recapitulation of R33's stay, which included medication reconciliation (a formalized process of creating the most accurate and complete list of a patient's current medications-including dosages, frequencies, and routes-and comparing it to their newly prescribed medications).On 06/10/26 at 10:44 AM, Social Service Designee (SSD) II and Administrative Nurse BB verified the facility failed to provide R5, R7, and R26 or their representative with a bed hold form or written notification of transfers to the hospital on the above dates. SSD II and Administrative Nurse BB stated they were unaware they were required to provide a written notice to residents or their representatives when they transferred to the hospital; the nurse who transferred them was responsible for notifying them. SSD II and Administrative Nurse BB stated the bed hold policy was provided to the residents or their representatives on admission.The facility's Bed-Holds and Returns Policy, revised October 2022, documented all residents /representatives would be provided written information regarding the facility and state bed-hold policies, which address holding (continued on next page)

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

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	or reserving a resident's bed during periods of absence (hospitalization or therapeutic leave)The facility's Transfer or Discharge, preparing a Resident for Policy, revised 12/2016, documented that when a resident was scheduled for transfer or discharge, the nursing services would be responsible for the following:Obtaining orders for discharge or transfer, as well as the recommended discharge services and equipment Preparing the discharge summary and post-discharge plan Preparing the medications to be discharged from the resident (as permitted by law) Providing the resident or representative with required documents (discharge summary and plan) Packing and collecting personal possessions Assisting with transportation as applicableEscorting the resident to transportationCompleting the discharge note in the medical record.The business office was responsible for informing the resident or his or her representative of the facility's bed-holding policy.

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to initiate interventions to prevent the development of a Stage 2 pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, because of pressure, or pressure in combination with shear and/or friction) for Resident (R) 26. Findings included:- R26's Electronic Health Record (EHR) revealed diagnosis of chronic kidney disease (long term condition where the kidneys are damaged and gradually lose their ability to filter waste), hyperkalemia (greater than normal amount of potassium in the blood), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), heart failure, and muscle weakness. R26's Significant Change Minimum Date Set (MDS), dated [DATE] recorded R26 had a Brief Interview for Metal Status (BIMS) score of 12, indicating moderately impaired cognition. The assessment revealed R27 required extensive staff assistance of two for bed mobility, personal hygiene, dressing, repositioning, and transfers. The resident was at risk for pressure ulcer development but had no skin issues or pressure ulcers. The MDS documented that the resident had a pressure-reducing device in her chair. R26's Skin Care Plan dated 02/23/26, documented R26 had potential for skin impairment due to fragile skin, impaired mobility, and bowel and bladder incontinence. The care plan documented staff would encourage good nutrition and hydration to promote healthier skin, encourage R26 to reposition often when sitting for long periods of time. The care plan documented staff to use caution with transfers and bed mobility to prevent striking arms, legs, and hands against any sharp or hard surface. R26's Activities of Daily Living (ADL) Care Plan dated 02/23/26, recorded R26 required extensive assistance of one to two staff with most ADLs. The Braden Scale for Predicting Pressure Ulcer assessment dated [DATE] documented a score of 15, which indicated the resident was at mild risk for pressure ulcer development.The Nurse Notes dated 05/11/26 at 10:59 AM, documented R26 had an intact blister on her left heel, and staff would float her heels and placed a pressure relieving boot on her left foot to prevent any further pressure to her left heel. The Nurse Notes dated 05/14/26 at 01:58 PM, documented the resident had labs and diagnosed with acute kidney failure and was sent to the hospital for further treatment. The Nurse Notes dated 05/18/26 at 12:00 PM, documented the resident returned to the facility and the left heel blister was intact. The Skin Notes dated 05/18/26 at 02:34 PM, documented blister to left heel progressed to an open area, facility acquired. The area measured 2.74 centimeters(cm) in length, by 2.4 cm in depth, with no tunneling. Small amount of serosanguineous (semi-thick blood-tinged drainage) drainage. Staff to use wound cleanser with a Silvercel (a specialized antimicrobial wound dressing that is used to manage heavy wound drainage while actively releasing silver ions to kill bacteria and prevent infection) dressing and border foam dressing (an advanced wound care bandage with an absorbent polyurethane foam pad in the center surrounded by soft, self-adhering border) two times a week. The Skin Notes dated 06/02/26 at 10:27 PM, documented an open area on the left heel, 1.36 cm in length by 1.32 cm in width, with no tunneling, mixture of serosanguineous drainage. Staff use wound cleanser with Silvercel dressing and covered with a border foam two times a week. R26's EHR documented a physician order dated 05/26/26 which directed staff to apply Silvercel to wound bed and cover with Mepilex Border Foam and change dressing every 72 hours and as needed if it becomes soiled or dislodged until the wound healed. On 06/09/26 at 03:20 PM, observation revealed R26 lying on her back in bed. Licensed Nurse (LN) A assisted Administrative Nurse BB to keep R26 left foot and leg elevated while she performed wound care to R26's left heel. Administrative Nurse BB cleansed R26's left heel with wound cleansed, then applied Silvercel wound dressing and covered with a Border Foam pad, there was no drainage noted. Administrative Nurse BB then applied a pressure relieving boot to R26's left heel and elevated it on a pressure relieving cushion. On 06/10/26 at 10:45 AM, Administrative Nurse BB verified R26's pressure ulcer was facility acquired and stated she developed it after she had a decline in condition. Administrative Nurse BB verified the resident (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	had a pressure relieving cushion in her chair but did not have a pressure relieving boot or offloading interventions prior to when she acquired the pressure area. The facility's Pressure Injury Risk Assessment policy, dated March 2020, documented the purpose of the pressure injury risk assessment was to identify a risk factor and then to determine which can be modified and which cannot, or which can be immediately addressed, and which will take time to modify. The facility would complete the risk assessment weekly for the first four weeks, if there is a significant change in condition, or as often as is required based on the residents' condition. Risk factors that increase a resident's susceptibility to develop or not heal a pressure injury include nutrition, malnutrition, and hydration deficits, impaired and decreased mobility and decreased functional ability. Once the assessment is conducted and risk factors are identified and characterized, a resident center care plan can be created to address and modifiable risks for pressure injuries.