STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175475	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enterprise Estates Nursing Center	602 Crestview Drive Enterprise, KS 67441

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 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Prevent the use of unnecessary psychotropic medications or use medications that may restrain a resident's ability to function. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with five residents sampled for unnecessary medication. Based on observation, interview, and record review, the facility failed to ensure Resident (R) 8 obtain an approved diagnosis for the use of Risperidone (an antipsychotic-class of medications used to treat major mental conditions which cause a break from reality) for dementia (progressive mental disorder characterized by failing memory, confusion) or the physician's rationale for why this specific drug was necessary to treat the condition.Findings included:- R8's Electronic Medical Record documented diagnoses of Lewy body dementia (type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), recurrent major depressive disorder, and impulse disorder (sudden, forceful, irresistible urges to do something).R8‘s Quarterly Minimum Data Set (MDS), dated [DATE], documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS documented R8 had no behaviors or mood issues. The MDS documented R8 required maximum staff assistance for activities of daily living and mobility. The MDS documented R8 received antipsychotic medication. R8‘s Care Plan, dated 03/25/25, directed staff to give medications as ordered, obtain labs as ordered, and provide gradual dose reductions as recommended by the pharmacist. The care plan stated the consultant pharmacist and the physician were to review medications monthly and make changes as needed. The care plan documented staff were to provide one-to-one reassurance and education regarding the disease process, medications, and procedures. The care plan documented staff were to list the last gradual dose reduction attempt of Risperidone and the physician's response. The Physician Order, dated 05/15/25, directed staff to administer Risperidone, 1 milligram (mg) daily at bedtime for Lewy Body Dementia with behavioral disturbance. The Consult Pharmacist Review, dated 05/09/25, requested the diagnosis for the use of R8's medications, including Risperidone. The physician responded and indicated Risperidone was for Lewy Body Dementia with behavioral disturbance. On 09/23/25 at 08:12 AM, Certified Medication Aide (CMA) M administered medications to R8 at the dining table. She crushed all medications and put them in vanilla pudding. R8 took the medications without problem.On 09/24/25 at 10:39 AM, Administrative Nurse D verified the diagnosis for the use of Risperidone was unapproved and the physician had not written a rationale for the unapproved use. The facility's undated Psychotropic Medication Use policy stated the physician's order for a psychotropic drug would include a qualifying diagnosis for that drug and the target behaviors for each specific drug. The attending physician must certify that a psychotropic medication was necessary to treat a specific condition or behavior.

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 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. (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	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on interviews and record review, the facility failed to notify the State Long Term Care Ombudsman (LTCO) of Resident (R) 30's facility-initiated discharge to the hospital. Findings included: - R30's Electronic Medical Record (EMR) revealed diagnoses of atherosclerotic health disease (a buildup of fats, cholesterol/plaque in the walls of the arteries obstructing blood flow), 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), diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), stage 3 renal failure (moderated damage to the kidneys and reduced kidney function), and hypocalcemia (abnormally low level of calcium in the blood).R30's scheduled 5-Day Minimum Data Set (MDS), dated [DATE], recorded R30 was cognitively intact. The MDS recorded she required extensive staff assistance with transfers and activities of daily living (ADL). The MDS documented R30 had frequent incontinence, required continuous oxygen, and ambulated with a wheelchair.The ADL Care Area Assessment (CAA) dated 11/13/24 recorded R30 required staff assistance with ADLs due to impaired functional ability. The CAA documented R30 had occasional incontinence of urine and required assistance with toileting, transfers, and hygiene. R30's Care Plan, dated 07/21/25, recorded R30 required staff assistance with most ADL care. R30's Care Plan documented the resident had chronic renal failure, monitored for signs and symptoms of infection. The Care Plan documented staff were to monitor the residents' heart and lung sounds as needed, document findings, and observe mental status, such as lethargy, fatigue, and tremors. The Nurse's Note on 06/09/25 at 01:02 PM documented R30 had a change in condition, was alert to orient to name and staff, but confused about place and date, and was able to feed herself without difficulty. The note documented R30 had jerking-like movement noted in the bilateral upper and lower extremities, with a heavy weight feeling to her extremities. The staff collected a blood sample for labs and a urine sample. The notes documented staff awaited a return phone call from the provider. The Nurse's Note on 06/09/25 at 03:41 PM documented the physician's office called and requested the resident to be transported to the walk-in clinic for further assessment and treatment. The resident was transported in the facility van. The Nurse's Note on 06/09/25 at 05:31 PM documented R30 was transported to the hospital and was evaluated in the emergency room.The Nurse's Note on 06/09/25 at 10:11 PM documented R30 had been admitted to the hospital for hyperkalemia.The Nurse's Note on 06/12/25 at 02:58 PM documented R30 returned to the facility at 02:30 PM, was alert and cooperative. R30 transferred into her recliner with two staff members and a gait belt.Review of the EMR documented R30 had a second hospital stay on 08/07/25. The Nurse's Note on 08/07/25 at 08:57 AM documented the resident was on an antibiotic for a urinary tract infection and was incontinent of urine. The Nurse's Note on 08/07/25 at 09:30 PM documented R30 had audible wheezing, staff elevated the head of her bed, and administered an inhaler to help with her breathing. The Nurse's Note on 08/07/25 at 11:40 PM documented the aide reported R30 had wheezing and a hard time breathing, staff administered. R30's oxygen was increased from two to four liters. Assisted with a rescue inhaler again and elevated the head of the bed. The note documented on 08/07/25 at 01:50 AM, staff called the ambulance to transport the resident to the hospital. The Nurse's Note on 08/08/25 at 04:31 AM documented R30 was admitted to the hospital for congestive heart failure exacerbations. The Nurse's Note on 08/11/25 at 09:58 AM documented R30 was discharged from the hospital and returned to the facility per the facility van. Review of the EMR noted R30's clinical record lacked documentation staff notified the LTCO of R30's discharge from the facility.On 09/23/25 at 03:10 PM, Social Service X stated they do not send any notification of discharge to the Ombudsman regarding the residents' discharge to the hospital. Social Service X verified they would notify the Ombudsman when a resident was discharged from the facility, home, or to another facility.The facility did not provide an Admission, Transfer, Discharge policy, as requested on 09/24/25.

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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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Develop the complete care plan within 7 days of the comprehensive assessment; and prepared, reviewed, and revised by a team of health professionals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to revise and update the care plan with Enhanced Barrier Precautions for Resident (R) 4 and R21 urinary catheters (a tube inserted into the bladder to drain the urine into a collection bag). The facility also failed to revise and update R3's falls care plan.Findings included: - R4's Electronic Medical Record (EMR) included diagnoses of benign prostatic hyperplasia without lower urinary tract symptoms (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), major depressive disorder (major mood disorder that causes persistent feelings of sadness), overactive bladder, need for assistance with personal care, retention of urine, muscle weakness, acute kidney failure, and generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R4 had severe cognitive impairment, was dependent on staff for toileting and personal hygiene, required substantial to maximal assistance with sitting to lying and lying to sitting, and partial to moderate assistance with bed to chair transfers and ambulating up to 150 feet. R4 had an indwelling urinary catheter and was frequently incontinent of bowel. The MDS further documented that R4 received scheduled pain medication and exhibited pain with vocal and facial expressions. R4 also received an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and an opioid (a medication to treat pain) medication. R4's Care Plan dated 06/14/25 documented that R4 has a suprapubic catheter (urinary bladder catheter inserted through the abdomen into the bladder) due to retention of urine. The Care Plan directed staff to provide catheter care every shift, empty, measure, and record urine output every shift, and monitor/record/report to the physician signs and symptoms of urinary tract infections. The Care Plan further directed staff to flush the catheter daily and change it monthly. The Physician Order dated 02/02/24 directed staff to change the indwelling catheter monthly at the urologist's (a specialist who treats disorders related to the urinary tract) office and as needed by nursing staff. The Physician Order further directed staff to cleanse the catheter site and cover with a split gauze daily. The Progress Note dated 08/25/25 at 10:46 AM documented that the urologist's catheter change was not covered by insurance, and R4's hospice services would provide the catheter change instead. On 09/23/25 at 09:56 AM, Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) R donned gloves, cleansed, and placed a split gauze at the catheter insertion site on R4's lower abdomen. The staff also provided other peri-hygiene, rolled the resident from side to side, and placed a clean brief. Staff lacked the use of a barrier gown during the care of the indwelling catheter. On 09/24/25 at 11:19 AM, Administrative Nurse E stated the staff should have utilized EBP for R4's catheter care, and EBP should be included in the care plan. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's undated Care Plan Revision policy states that documented revisions to the care plan will be the responsibility of a Licensed Nurse in collaboration with the resident, the representative/family, direct care staff, and the entire interdisciplinary team, and changes would be communicated with all staff and shifts. - R21's Electronic Medical Record (EMR) included diagnoses of retention of urine, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), heart failure, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), post-laminectomy (a surgical procedure to remove the bony arch of the spine bone), need for assistance with personal care, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R21's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R21 had intact cognition, required supervision or touch assistance with toileting and personal hygiene, partial to moderate assistance with bathing, and lower body dressing. R21 had an indwelling catheter and was continent of bowel. The MDS further documented R21 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), diuretic (a medication to promote the formation and excretion of urine), opioid (medication to treat pain), and anticonvulsant (a class of medications use to control seizures) medications. R21's Care Plan dated 05/27/25 documented that R21 had an indwelling catheter due to retention of urine. The Care Plan directed staff to provide catheter care every shift, ensure the catheter and tubing remain below the level of the bladder, and ensure the drainage bag was placed in a privacy bag. The staff also needed to monitor and document pain/discomfort due to the catheter. The Physician Order dated 06/09/25, directed the staff to change the catheter every month and as needed for dislodgement. The Progress Note dated 09/05/25 at 11:18 AM documented that the catheter was removed intact without difficulty, and a new catheter was inserted with immediate return of urine. On 09/23/25 at 12:06 PM, Certified Nurse Aide (CNA) M assisted R21 out of bed for the lunch meal. CNA M, without gloves, removed the urine collection bag, which had been hooked onto the bed frame, and placed the drainage bag into a privacy bag attached to the walker. On 09/24/25 at 11:19 AM, Administrative Nurse E stated the staff should have utilized EBP for R21's catheter care, and EBP should be included in the care plan. The facility's undated Care Plan Revision policy states that documented revisions to the care plan will be the responsibility of a Licensed Nurse in collaboration with the resident, the representative/family, direct care staff, and the entire interdisciplinary team, and changes would be communicated with all staff and shifts. (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 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	- R3's Electronic Medical Record (EMR) revealed a diagnosis of dementia (progressive mental disorder characterized by falling memory, confusion), major depressive disorder (major mood disorder which causes persistent feelings of sadness), hypertension (elevated blood pressure), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R3's Quarterly Minimum Data Set (MDS), dated [DATE], recorded R3 had severely impaired cognition. The MDS recorded he required the assistance of one staff member for transfers and activities of daily living (ADL). The MDS further documented R3 had one fall with no injury and one fall with major injury. R3's Care Plan dated 11/01/24 recorded R3 was independent with transfers and used a walker to help maintain balance while ambulating, and would forget his walker often. The Care Plan documented the staff would intervene and assist R3 when he would be holding up items and not utilizing the walker. The care plan recorded R3 was exit seeking and would demand to leave, and staff would redirect and offer to take him out on the patio with staff supervision. The Fall Risk Assessments dated 09/24/24 noted R3 had a score of 17.0, which indicated he was at risk for falls. The Fall Risk Assessment dated 07/15/25 noted R3 had a score of 14.0, which indicated he was at risk for falls. The Nurse's Note dated 01/11/25 at 01:51 PM documented the resident was observed sitting on the floor in the dining room attempting to get up into a regular chair. Staff assisted the resident up to his feet with two staff assist and a gait belt to a regular chair. Observation revealed the resident had hit his left ear and head on the wall. Continued observation revealed the resident had a 2.5-centimeter (cm) laceration to his left temporal lobe, directly above and behind his left ear. The area was cleansed, pressure and cold pack applied for 20 minutes. R3 tolerated well and the laceration sealed on its own, reinforced with three steri-strips. R3 had 2.0 cm laceration to his superior left auricle. Staff cleansed and approximated the laceration with three steri-strips. Neuro checks were initiated, and the resident was alert and answered questions appropriately. Staff obtained the residents' vital signs that were within normal limits, and the resident was assisted to his room to lie down after staff provided incontinence cares. R3 legs were examined and equal length bilaterally, and the staff observed no external rotation. The resident denied further complaints of pain; the physician, Director of Nursing, and emergency contact were notified. The clinical record lacked documentation of a resident-centered intervention was put into place to prevent falls, and lacked documentation an investigation was completed for the fall. The Post Fall Evaluation dated 01/13/25 at 11:42 AM documented R3 had a fall on 01/11/25 at 11:15 AM that was not witnessed. The fall occurred in the dining room, and R3 had attempted to transfer himself from his wheelchair to a chair in the dining room. The notes documented the resident received a 2.5 cm laceration to his left temporal lobe and a 2.0 cm laceration to his left auricle. The note documented the resident's wheelchair was unlocked at the time of the fall. (continued on next page)

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F 0657 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 09/22/25 at 04:10 PM, observation revealed R3 standing in his room, then ambulated into the hall. Observation revealed the resident was unsteady and had to hold onto the door frame to steady himself as he ambulated. Staff were notified, and the resident returned to his room and sat in his wheelchair, then propelled himself to the dining room. On 09/23/25 at 11:45 AM, Administrative Nurse E stated she or Administrative Nurse D was not working at the facility at the time of the resident's fall, so was unaware if an investigation was completed, but upon review, was unable to find an investigation with witness statements. Administrative Nurse E verified the staff should report an unwitnessed fall with injury to the administration, and an investigation would be completed along with witness statements and reported to the state if indicated. On 09/23/25 at 11:45 AM, Administrative Nurse E stated she or Administrative Nurse D was not working at the facility at the time of R3's fall, so was unaware if an investigation was completed, but upon review, was unable to find an investigation with witness statements. Administrative Nurse E verified the staff should report an unwitnessed fall with injury to the administration, and an investigation would be completed along with witness statements and reported to the state if indicated. Administrative Nurse E stated the care plan should be updated with each fall, including interventions, and R3's care plan was not updated. The facility's Care Plan policy, undated, documented the care planning process includes assessment. Goal setting, intervention, referrals to other health care professionals, evaluations of resident responses to treatment, and revision of care and treatment in order to meet the resident's needs. The policy documented changes in the care plan would be required in the event the resident experienced an adverse event, including after every fall, to include specific instructions to staff based on the causal factors identified at the time of the occurrence and during the fall investigatory process to prevent or reduce the possibility for recurrence of a fall.

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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. (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to provide physician-ordered interventions to treat or prevent pressure wounds for Resident (R) 8 when staff failed to apply a pressure relief air overlay device on R8's bed. Findings included:- R8's Electronic Medical Record documented diagnoses of diabetes mellitus (DM- when the body cannot use glucose, not enough insulin made or the body cannot respond to the insulin), Parkinson's disease (slowly progressive neurologic disorder characterized by resting tremor, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity and weakness), localized edema (swelling resulting from an excessive accumulation of fluid in the body tissues), and pressure-induced deep tissue damage of the left heel.R8's Quarterly Minimum Data Set (MDS), dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS documented R8 had no behaviors or mood issues. The MDS documented R8 required maximum staff assistance for activities of daily living and mobility. The MDS documented R8 had one unstageable pressure ulcer (PU- localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction), and interventions included pressure relief to bed and chair, repositioning, nutrition, and PU care. The MDS documented R8 received antipsychotic (class of medications used to treat major mental conditions, which cause a break from reality) medication. R8's Care Plan dated 03/25/25 directed staff to report any skin changes to the nurse, keep skin clean and dry, and provide weekly skin checks by a nurse. The care plan stated staff were to provide a Magic Cup (frozen nutritional supplement) at lunch and supper, a Mighty Shake (high-calorie nutritional supplement) or nutritional equivalent with all meals, and Arginaid (a nonprescription nutritional drink that supplies the amino acid L-arginine along with vitamin C and E) or nutritional equivalent with all meals. R8's Braden Scale for Pressure Ulcer Risk dated 06/21/25 documented R8 was at high risk of developing pressure ulcers. The Physician Order dated 04/17/25 directed staff to apply Collagen (protein derived wound treatment used to promote wound healing), Hydrofera Blue (a type of moist wound dressing which provides wound protection and addresses bacteria and yeast) Classic foam dressing, cut to wound size, and lightly moisten with saline and squeeze out excess moisture, apply to left posterior medial heel and cover with Opti foam or Alevyn dressing, and change three times weekly. The Physician Order dated 06/29/25 directed staff to offload both feet and heel pressure with a pillow, pressure relief boots, and use an air overlay on his mattress every day and night shift. The Dietary Note dated 08/23/25 documented R8 received a regular diet. His intake was variable and had orders for a MVI (multivitamin), house supplement, and Arginaid to assist with wound healing of his left heel. The Skin Check dated 08/27/25 stated R8's left heel PU was resolved. The Skin Check dated 09/11/25 stated left heel scabbing intact and documented no measurements. No measurements or wound characteristics were documented.The Skin Check dated 09/17/25 stated left heel scabbing intact, and progress stalled. No measurements or wound characteristics were documented. On 09/23/25 at 10:55 AM, Licensed Nurse (LN) G checked R8's left foot dressing. She washed her hands and gloved, but did not don enhanced barrier precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care). LN G peeled the heel wound dressing back and decided to change the dressing. He had a small open area, approximately 1 x 1 centimeters (cm), on the back of his left heel. R8's left foot was very swollen, and his toes were reddish in color. LN G cleansed the wound and applied a new dressing. LN G stated she was unsure when the PU reopened. It was the same area that R8 had when he was originally admitted . LN G verified she was supposed to measure the wound, but had not. LN G stated staff were to float his feet with pillows at night, and place pressure relief booties on during the day. LN G verified R8's bed did not have an air overlay mattress on the bed as ordered. On 09/24/25 at 10:25 AM, Certified Medication Aide (CMA) R verified R8's bed had no air overlay mattress. On 09/24/25 at 10:39 AM, Administrative Nurse D verified staff should have placed an air overlay device on R8's bed as ordered, documented weekly skin assessments, and documented interventions and updates to the care plan. She stated she had attempted to get the wound clinic to come to the facility without success. The facility did not provide a policy regarding the prevention and treatment of pressure ulcers when requested on 09/25/25.

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Try different approaches before using a bed rail. If a bed rail is needed, the facility must (1) assess a resident for safety risk; (2) review these risks and benefits with the resident/representative; (3) get informed consent; and (4) Correctly install and maintain the bed rail. (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 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with one reviewed for side rails. Based on observation, interview, and record review, the facility failed to assess the actual rail being used to assure safety for Resident (R) 7. Findings included: - The Electronic Medical Record (EMR) for R7's of hemiparesis (muscular weakness of one half of the body), hemiplegia (paralysis of one side of the body), transient ischemic attack (TIA- temporary episode of inadequate blood supply to the brain), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and chronic pain.R7's Quarterly Minimum Data Set (MDS) dated [DATE] recorded the resident had a Brief Interview for Mental Status (BIMS) score of nine, indicating mild cognitive impairment. The MDS documented R7 required substantial assistance with mobility and rolling left to right. The MDS lacked documentation the resident had siderails. R7's medical record lacked a Side Rail Assessment and safe use for the side rail. On 09/23/25 at 09:00 AM, observation revealed R7 lying in bed on her back watching TV. Continued observation revealed a side rail on the right side of R7's bed. The side rail on the top right side with openings approximately 12 and one-half inches wide and approximately 18 inches from the top of the rail to the mattress.On 09/23/25 at 09:10 AM, Administrative Nurse D and Administrative Nurse E verified that the staff should assess the bed rail or safety quarterly or with a significant change in the resident's status. Administrative Nurse D verified R7's bed rails had too large of openings, and R7's EMR lacked an assessment for the siderail.The facility's Bed Rails policy, undated, documented each resident has the right to be free from any physical restraint imposed for the purpose of discipline or convenience, and if the use is not required to treat the resident's medical symptoms. It is the policy of the facility to be a restraint-free environment without jeopardizing resident safety. The facility would attempt to use an appropriate alternative prior to installing a side or bed rail. If a bed rail is used, the facility would ensure correct installation, use, and maintenance of the bed rails, including but not limited to: assessment of the resident for risk of entrapment from bed rails prior to installation, review of risks and benefits of bed rails with the resident/representative, and obtain informed consent prior to installation. The policy documented to ensure that the bed's dimensions are appropriate for the resident's size and weight, follow the manufacturer's recommendations and specifications for maintaining bed rails. It is the policy of the facility to identify and reduce safety risks and hazards commonly associated with the use of bed rails or other bed mobility safety devices. The facility's regular maintenance program would include regular inspection of all bed systems, including but not limited to bed rails, bed frames, mattresses, and operational components of each bed to ensure a safe, clean, comfortable and homelike environment. The facility would also ensure bed rail assessments and evaluations are performed on a regular basis. Individual bed rail evaluations would include data collection, analysis, and determination of potential alternatives to the use of bed rails. When bed rails are deemed necessary and appropriate, the facility would provide education to residents and/or representatives pertaining to the risks and benefits of bed rail use. The facility's priority is to ensure safe and appropriate bed rail use. The purpose of the policy is to assist residents, representatives, physicians, and facility staff in determining if resident use of bed rails is safe and appropriate. The Interdisciplinary team would use data collection from regular bed inspections and individual bed rail assessments, and evaluations to assist in care planning and positive resident outcomes. The policy documented upon admission, the resident would be screened to determine if care needs may necessitate specialized beds or accessories, including but not limited to bed rails or other bed mobility devices. Assessment of need for special equipment or accessories to assess the resident to identify appropriate alternatives to installing bed rails or other bed mobility devices, and assess the resident for risk of entrapment from the bed rails prior to installation. Obtain and retain in the resident's clinical record, Informed consent for the use of bed rails and bed mobility enhancing devices. Gap measurements would be performed prior to installation and at least quarterly to ensure safety from potential entrapment following FDA guidelines for acceptable gaps: any open space between parameters of rail can present a risk of head entrapment, with the FDA-recommended space less than 4 and 3/4 inches.

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	175475	A. Building B. Wing	11/17/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Enterprise Estates Nursing Center	602 Crestview Drive Enterprise, KS 67441

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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 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** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review the facility's nursing staff failed to follow physician orders to obtain adequate blood samples for Resident (R) 6 's laboratory testing and further failed to obtain physician involvement for direction related to continued Coumadin (anticoagulant-blood thinning drug) and Lovenox (anticoagulant-blood thinning drug) administration without the required monitoring. Findings included:- R6's Electronic Medical Record documented diagnoses of cerebral infarction (stroke) affecting right dominant side, aphasia (condition with disordered or absent language function), hypertension (elevated blood pressure), and atrial fibrillation (rapid, irregular pulse). R6's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented R6 required staff assistance with activities of daily living, reported no pain and received anticoagulant (blood-thinning medication).R6's Care Plan dated 02/11/25 directed staff to administer medications as prescribed and monitor laboratory results. On 09/04/25, R6 was hospitalized and returned to the facility on [DATE] with physician orders for a daily INR (international normalized ratio -blood test which measures how long it takes for the blood to clot) until the goal INR was met. R6 had orders for Coumadin and Lovenox daily. On 09/11/25, R6's Medication Administration Record (MAR)/Treatment Administration Record (TAR) lacked documentation regarding the order to draw a PT (Prothrombin Time- a blood test that measures the time it takes for blood to clot)/INR, and no lab was obtained that day, and lacked evidence the physician was notified. R6 received her Coumadin and Lovenox. On 09/12/25, R6's EMR documented staff attempted two times to draw blood for INR testing, but did not draw an adequate amount for testing on the first attempt, and was unable to obtain a sample on the second attempt. Staff did not notify the physician of the failed efforts and the inability to obtain an INR result. R6 received her Coumadin and Lovenox. On 09/13/25, R6's EMR documented R6 declined to go to the lab for a blood draw until after the lab was closed. R6's clinical record lacked documentation staff attempted to draw the blood at the facility or notify the physician of the lack of an INR. R6 received her Coumadin and Lovenox.On 09/14/25, R6's EMR documented staff did not draw a blood sample for the INR because the lab was closed, though staff did not notify the physician regarding the missed INR. R6 received her Coumadin and Lovenox.On 09/15/25, R6's EMR documented R6 had a PT/INR drawn, which resulted in a critically high INR of 11.6.On 09/22/25 at 10:30 AM, R6 sat in her wheelchair visiting with a nurse at the nurse station. R6 was slow to verbalize. No abnormal bruising was observed.On 09/23/25 at 10:43 AM, Licensed Nurse (LN) G stated R6 came back from the hospital on [DATE] with orders for daily INR labwork. On 09/24/25 at 11:22 AM, Administrative Nurse D verified the daily INR labs had not been done as ordered.The facility did not provide a policy related to nursing services, as requested on 09/24/25.

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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. The facility had a census of 27 residents. The sample included 12 residents. Based on observation and record review, the facility failed to ensure the required annual performance reviews were completed for the three members reviewed. Findings included: - A review of the facility nurse and nurse aide performance evaluations revealed that Certified Medication Aide (CMA) R was hired on 03/21/24, Certified Nurse Aide (CNA) M was hired on 06/21/23, and CNA N was hired on 07/06/21. Randomly selected employees, who had been employed for over a year, lacked an annual review.On 09/23/25 at 11:06 AM, Administrative Staff B reported the facility had an annual review from 2023, but not for 2024. Administrative Staff B stated the facility had new administrative staff and had not performed an annual review.The facility's undated Employee Annual Performance Evaluation form included knowledge, skillset, judgement, quality of work, productivity and dependability, communication, initiative, and resident/family focus, which scored the employee for a percentage wage increase.Upon request, the facility failed to provide an Employee Performance Evaluation Policy.

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F 0756 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure a licensed pharmacist perform a monthly drug regimen review, including the medical chart, following irregularity reporting guidelines in developed policies and procedures. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents, with five residents reviewed for unnecessary drugs. Based on observation, interview, and record review, the facility failed to ensure the consult pharmacist notified the physician or the director of nursing of the need for further documentation regarding the continued use of Risperidone (antipsychotic medication- a class of medications used to treat major mental conditions that cause a break from reality) for Resident (R) 8 related to the unapproved diagnosis.Findings included:- R8's Electronic Medical Record (EMR) documented diagnoses of Lewy body dementia (type of progressive brain disorder that leads to a decline in thinking, reasoning, and independent function), anxiety disorder (mental or emotional reaction characterized by apprehension, uncertainty and irrational fear), recurrent major depressive disorder, and impulse disorder (sudden, forceful, irresistible urges to do something).R8's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS documented R8 had no behaviors or mood issues. The MDS documented R8 required maximum staff assistance for activities of daily living and mobility. The MDS documented R8 received antipsychotic medication. R8's Care Plan dated 03/25/25 directed staff to give medications as ordered, obtain labs as ordered, and provide gradual dose reductions as recommended by the pharmacist. The care plan stated the consultant pharmacist and the physician were to review medications monthly and make changes as needed. The care plan documented staff were to provide one-to-one reassurance and education regarding the disease process, medications, and procedures. The care plan documented staff were to list the last gradual dose reduction attempt of Risperidone and the physician's response.The Physician Order dated 05/15/25 directed staff to administer Risperidone, 1 milligram (mg) daily at bedtime for Lewy Body Dementia with behavioral disturbance. The Consult Pharmacist Review dated 05/09/25 requested the diagnosis for the use of R8's medications including Risperidone. The physician responded and indicated Risperidone was for Lewy Body Dementia with behavioral disturbance.On 09/23/25 at 08:12 AM, Certified Medication Aide (CMA) M administered medications to R8 at the dining table. She crushed all medications and put them in vanilla pudding. R8 took the medications without problem.On 09/24/25 at 10:39 AM, Administrative Nurse D verified the diagnosis for the use of Risperidone was unapproved and the physician had not written a rationale for the unapproved use. She verified the consultant pharmacist had not attempted to notify the physician or the director of nursing of the need for further documentation regarding the continued use of Risperidone for the unapproved diagnosis.The facility did not provide a policy on pharmacy reviews, as requested on 09/24/25.

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F 0770 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide timely, quality laboratory services/tests to meet the needs of residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to obtain adequate blood samples for Resident (R) 6 's laboratory testing and further failed to obtain physician involvement for direction related to continued Coumadin (anticoagulant-blood thinning drug) and Lovenox (anticoagulant-blood thinning drug) administration without the required monitoring. Findings included: - R6's Electronic Medical Record (EMR) documented diagnoses of cerebral infarction (stroke) affecting right dominant side, aphasia (condition with disordered or absent language function), hypertension (elevated blood pressure), and atrial fibrillation (rapid, irregular pulse). R6's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, indicating intact cognition. The MDS documented R6 required staff assistance with activities of daily living, reported no pain, and received anticoagulant (blood-thinning medication). R6's Care Plan dated 02/11/25 directed staff to administer medications as prescribed and monitor laboratory results. On 09/04/25 R6 was hospitalized . R6 returned to the facility on [DATE] with physician orders for a daily INR (international normalized ratio- a blood test which measures how long it takes for the blood to clot) until the goal INR was met. R6 had orders for Coumadin and Lovenox daily.On 09/11/25, R6's Medication Administration Record (MAR)/Treatment Administration Record (TAR) lacked documentation regarding the order to draw a PT (Prothrombin Time- a blood test that measures the time it takes for blood to clot) /INR, and no lab was obtained that day, and lacked evidence the physician was notified. R6 received her Coumadin and Lovenox. On 09/12/25, R6's EMR documented staff attempted two times to draw blood for INR testing, but did not draw an adequate amount for testing on the first attempt, and was unable to obtain a sample on the second attempt. Staff did not notify the physician of the failed efforts and the inability to obtain an INR result. R6 received her Coumadin and Lovenox. On 09/13/25, R6's EMR documented R6 declined to go to the lab for a blood draw until after the lab was closed. R6's clinical record lacked documentation staff attempted to draw the blood at the facility or notify the physician of the lack of an INR. R6 received her Coumadin and Lovenox. On 09/14/25, R6's EMR documented staff did not draw a blood sample for the INR because the lab was closed, though staff did not notify the physician regarding the missed INR. R6 received her Coumadin and Lovenox. On 09/15/25, R6's EMR documented R6 had a PT/INR drawn, which resulted in a critically high INR of 11.6.On 09/22/25 at 10:30 AM, R6 sat in her wheelchair visiting with a nurse at the nurse station. R6 was slow to verbalize. No abnormal bruising was observed.On 09/23/25 at 10:43 AM, Licensed Nurse (LN) G stated R6 came back from the hospital on [DATE] with orders for daily INR lab work. On 09/24/25 at 11:22 AM, Administrative Nurse D verified the daily INR labs had not been done as ordered. She stated on Saturdays, the lab was only open until 09:30 AM, and on Sunday, 09/14/25, the emergency department would not be able to draw the lab due to the lab was not open to run it. The facility's undated Laboratory Policy and Procedure stated the facility would ensure all laboratory tests were performed accurately, safely, and in a timely manner to support resident care. Nurses were responsible for collecting, handling, and processing laboratory specimens according to standard protocol and regulations. Proper documentation and communication of results were essential for resident safety and quality care.

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F 0868 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have the Quality Assessment and Assurance group have the required members and meet at least quarterly The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to maintain a Quality Assurance Assessment and Assurance committee (QA&A) that met quarterly and had the required membership in attendance.Findings included:- The facility provided QA&A committee attendance rosters for 01/23/25, 02/07/25, 07/02/25, and 09/11/25. Upon review of the rosters, the Medical Director signed in attendance on 02/07/25 and 09/11/25. On 09/24/25 at 02:27 PM, Administrative Staff A reported she had begun employment with the facility in July 2025 and could find limited information from the previous administrator's QA&A process. Administrative Staff A stated she had not had training related to the QA&A process but had a meeting involving the Medical Director on 09/11/25.The facility's Quality Assurance policy, dated 07/20/16, documented that the Quality Assurance Team would meet on a monthly and quarterly basis to ensure quality care and compliance with regulations. The facility shall maintain a quality assessment and assurance consisting of the director of nursing, a physician designated by the facility, and at least three members of the facility staff.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Provide and implement an infection prevention and control program. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 27 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to implement Enhanced Barrier Precautions (EBP- infection control interventions designed to reduce transmission of resistant organisms, which employ targeted gown and glove use during high contact care) for Resident (R) 4 and R21 urinary catheter care (tube placed in the bladder to drain urine into a collection bag). The facility also failed to have a structured Infection Control program. Finding included: - R4's Electronic Medical Record (EMR) included diagnoses of benign prostatic hyperplasia without lower urinary tract symptoms (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), major depressive disorder (major mood disorder that causes persistent feelings of sadness), overactive bladder, need for assistance with personal care, retention of urine, muscle weakness, acute kidney failure, and generalized anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) disorder. R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented R4 had severe cognitive impairment, was dependent on staff for toileting and personal hygiene, required substantial/maximal assistance with sitting to lying and lying to sitting, and partial to moderate assistance with bed to chair transfers and ambulating up to 150 feet. R4 had an indwelling urinary catheter and was frequently incontinent of bowel. The MDS further documented that R4 received scheduled pain medication and exhibited pain with vocal and facial expressions. R4 also received an antianxiety (a class of medications that calm and relax people), an antidepressant (a class of medications used to treat mood disorders), and an opioid (a medication to treat pain). R4's Care Plan dated 06/14/25 documented that R4 has a suprapubic catheter due to retention of urine. The Care Plan directed staff to provide catheter care every shift, empty, measure, and record urine output every shift, and monitor/record/report to the physician signs and symptoms of urinary tract infections. The Care Plan further directed staff to flush the catheter daily and change it monthly. The Physician Order dated 02/02/24 directed staff to change the indwelling catheter monthly at the urologist's (a specialist who treats disorders related to the urinary tract) office and as needed by nursing staff. The Physician Order further directed staff to cleanse the catheter site and cover with a split gauze daily. The Progress Note dated 08/25/25 at 10:46 AM documented that the urologist's catheter change was not covered by insurance, and R4's hospice services would provide the catheter change instead. On 09/23/25 at 09:56 AM, Certified Nurse Aide (CNA) M and Certified Medication Aide (CMA) R donned gloves, cleansed, and placed a split gauze at the catheter insertion site on R4's lower abdomen. The staff also provided other peri-hygiene, rolled the resident from side to side, and placed a clean brief. Staff lacked the use of a barrier gown during the care of the indwelling catheter. On 09/24/25 at 11:19 AM, Administrative Nurse E stated the staff should have utilized EBP for R4's catheter care, and EBP should be included in the care plan. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	The facility's Evidence-Based Practice (EBP) Policy and Procedure dated 09/23/25 documented that the Administrator/Director of Nursing ensures organizational support, including resources for education and literature access. Approved EBP projects and allocated staff time. - R21's Electronic Medical Record (EMR) included diagnoses of retention of urine, diabetes mellitus (DM- when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), heart failure, benign prostatic hyperplasia (BPH- non-cancerous enlargement of the prostate which can lead to interference with urine flow, urinary frequency, and urinary tract infections), post-laminectomy (a surgical procedure to remove the bony arch of the spine bone), need for assistance with personal care, and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R21's Quarterly Minimum Data Set (MDS) dated [DATE] documented that R21 had intact cognition, required supervision or touch assistance with toileting and personal hygiene, partial to moderate assistance with bathing, and lower body dressing. R21 had an indwelling catheter and was continent of bowel. The MDS further documented R21 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), diuretic (a medication to promote the formation and excretion of urine), opioid (medication to treat pain), and anticonvulsant (a class of medications use to control seizures) medications. R21's Care Plan dated 05/27/25 documented R21 had an indwelling catheter due to retention of urine. The Care Plan directed staff to provide catheter care every shift, ensure the catheter and tubing remain below the level of the bladder, and ensure the drainage bag is in a privacy bag. The staff also needed to monitor and document pain/discomfort due to the catheter. The Physician Order dated 06/09/25 directed the staff to change the catheter every month and as needed for dislodgement. The Progress Note dated 09/05/25 at 11:18 AM documented that the catheter was removed intact without difficulty, and a new catheter was inserted with immediate return of urine. On 02/23/25 at 12:06 PM, Certified Nurse Aide (CNA) M assisted R21 out of bed for the lunch meal. CNA M, without gloves, removed the urine collection bag, which had been hooked onto the bed frame, and placed the drainage bag into a privacy bag attached to the walker. On 09/24/25 at 11:19 AM, Administrative Nurse E stated the staff should have utilized EBP for R4's catheter care, and EBP should be included in the care plan. The facility's Evidence-Based Practice (EBP) Policy and Procedure dated 09/23/25 documented that the Administrator/Director of Nursing ensures organizational support, including resources for education and literature access. Approved EBP projects and allocated staff time. - On 09/25/25 at 08:00 AM, review of the facility infection control program revealed a lack of documentation for tracking infections from October 2024 to September 2025, which included the type of infection, antibiotic usage, resolution of the infection, and additional cultures. Continued review revealed a lack of identifying, tracking, monitoring, and/or reporting of infections. (continued on next page)

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	On 09/25/25 at 08:00 AM, Administrative Nurse E stated she had received her Infection Preventionist (IP) certification and was responsible for the Infection Prevention and Control Program, and verified she had not tracked the infections for the last few months. Administrative Nurse E stated that when she started a few months ago, she had many jobs to fill and did not track the infections. Administrative Nurse E verified the designated facility prior to IP no longer working at the facility, and they were unable to find prior documentation of the infections for the last year. On 09/24/25 at 11:10 AM, Administrative Nurse D verified the facility had not tracked infections from October 2024 to the present. Administrative Nurse D said the facility would start a system to identify infections on a map of the facility, but lacked complete documentation for the infection control programs inclusion in the policy and infection control guidelines. The facility's Infection Control policy, undated, documented the facility would facilitate safe care of all residents and staff with known or suspected communicable diseases by establishing and maintaining an infection prevention and control program designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. The policy applies to all staff members from all departments of the facility, including direct and indirect care staff, contracted staff, consultants, volunteers, and others who provide care and services to residents on behalf of the facility, and students in a facility -supported training program, contracted and vendors of facility, residents residing in the facility, and visitor sin the facility. The Infection Prevention and Control Program would follow accepted Federal standards, including but not limited to the Centers for Disease Control (CDC), and is based on facility assessment and includes prevention, identification, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual agreement. The Infection Control Program includes surveillance, investigation, controlling and preventing infections in the facility including appropriate immunizations, appropriate reporting of infection incidents, standard and transmission -based precautions to prevent spread of infection, development of procedures such as isolation and quarantine to be applied to an individual resident, circumstances to prohibit employees with communicable diseases or other infectious state from direct contact with residents or food, hand hygiene for staff involved in direct care contact, and maintaining a record of incidents and corrective actions related to infections. The infection control prevention and control program and antibiotic stewardship program is a function of the multidisciplinary, interdisciplinary team, including but not limited to the Medical Director, Director of Nursing, Infection Control Preventionist or designee, Administrator, and Consulting Pharmacist.