STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175480	A. Building B. Wing	12/03/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Logan Manor Community Health Services	108 S Adams Street Logan, KS 67646

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 0550 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Honor the resident's right to a dignified existence, self-determination, communication, and to exercise his or her rights. The facility had a census of 32. The sample included 12 residents. Based on record review, interview, and observation, the facility failed to provide care for Resident (R) 7 in a manner that protected and promoted their dignity. Findings included:- On 12/02/25 at 07:30 AM, observation revealed R7 sat in a chair at the dining room table. Licensed Nurse (LN) G obtained R7's blood sugar reading using a glucometer (an instrument used to calculate blood glucose) from R7's left index finger. LN G then stated to the residents, Your blood sugar reading is 120. Continued observation revealed two residents were seated in the dining room awaiting breakfast to be served, while staff and other residents were in the hallways adjacent to the dining room.On 12/03/25 at 08:15 AM, Administrative Staff A stated staff should not check residents' blood sugar in a common area; staff should take the resident to their room or to a private area.The facility's Residents Dignity policy, dated 10/22/24, documented each resident had the right and would be afforded the right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility without interference, coercion, discrimination, or reprisal. Residents' rights include but are not limited to privacy and confidentiality.

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

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

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(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 32 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observations, interview, and record review, the facility failed to ensure a 14-day stop date or a specified duration with a rationale for Resident (R) 32's ongoing as-needed (PRN) antianxiety (class of medications that calm and relax people) medication. Findings included:- R32's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (progressive mental disorder characterized by failing memory, confusion), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R32's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R32 had severely impaired cognition. The MDS recorded she required extensive assistance from staff with activities of daily living (ADL). The MDS documented R32 received an antianxiety medication during the observation period.R32's Care Plan dated 08/07/25 recorded R32 required one staff assistance with most ADL care. R32's care plan documented the resident had a mood problem related to depressive disorder and anxiety with physical and verbal aggression and resistance to cares. The care plan documented the resident received a mental health consult monthly and as needed, and staff would administer medications as ordered and document for side effects and effectiveness.R32's Physician's Order dated 03/25/25 directed the staff to administer Ativan (lorazepam-antianxiety) cream 1.0 milligram (mg)/per milliliter (ml), every six hours as needed for anxiety/aggression related to anxiety disorder. The order lacked a stop date.R32's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN Ativan (lorazepam).On 12/01/25 at 12:30 PM, R32 sat in a wheelchair in the Pod three hallway. Continued observation revealed the resident went to the partially opened equipment door, touched the door handle, then propelled down the hall to the East exit door. Continued observation revealed the resident went to the East exit door and tried to grab at the door frame and was unable to open the door, then turned around and started propelling back down the hall to Pod three.On 12/01/25 at 12:40 PM, Certified Medication Aide (CMA) S verified the resident had received Ativan cream to her wrist approximately 20 minutes ago and stated she had been agitated and staff were not able to be redirected her, so the nurse administered the Ativan cream to R38's wrist. CMA S verified the medication takes approximately one hour to kick in.On 12/03/25 at 08:15 AM, Administrative Staff A verified the resident received Ativan cream PRN, with a physician order date of 03/25/25. Administrative Staff A verified the facility failed to obtain the 14-days stop date or a reason for the continued use with the appropriate rationale.The Antipsychotic Medication Use policy, dated 09/26/25, recorded antipsychotic medication would be prescribed when indicated by assessment and medical necessity and after other non-pharmacological interventions or alternatives had been considered or used, and at the lowest effective therapeutic dose for the shortest effective duration. The policy stated each resident who had an order for an antipsychotic medication would be assessed and periodically reassessed during their stay to determine the effectiveness of the medication.

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F 0610 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Respond appropriately to all alleged violations. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to complete an investigation, including root cause analysis for one resident who had falls, Resident (R) 19.Findings included:- The Electronic Medical Record (EMR) for R19 documented diagnoses of hypertension (high blood pressure), transient ischemic attack (TIA- a temporary episode of inadequate blood supply to the brain), and chronic kidney disease (a long-term condition where your kidneys become damaged and can't filter waste and extra fluid from the blood).The Annal Minimum Data Set (MDS) dated [DATE] documented R19 had intact cognition. R19 was dependent upon staff for toileting hygiene, showers, and lower-body dressing. R19 required substantial staff assistance for oral hygiene, upper body dressing, personal hygiene, mobility, and transfers. R19 had upper functional impairment on both sides and had one fall with injury.R19's Quarterly MDS dated 09/10/25 documented R19 had severely impaired cognition. R19 required substantial staff assistance for showers, dressing, personal hygiene, mobility, transfers, and partial staff assistance for ambulation. R19 had upper functional impairment on both sides and had no falls.The Fall Risk Assessment dated 03/23/25, 06/18/25, and 09/08/25 documented R19 was a high risk for falls.R19's 09/04/25 Care Plan included the following interventions:05/17/24 - Use a gait belt with all transfers.09/15/24 - Ensure R19 had socks and shoes on with transfers and ambulation during the day.11/30/24 - Use a wheelchair instead of ambulating when weak. 06/13/25 - Reeducate Licensed Nurse (LN) and Activity Director (AD) on how to load R19 into the facility van and to have foot pedals on her wheelchair.The Nurse's Note dated 06/13/25 at 03:57 PM (late entry) documented while leaving the museum, LN I and Activity Z loaded R19 into the wheelchair van, pulled her up the ramp, which had the resident tilt forward. R19 slowly slipped forward out of the chair and slid to the ramp on her bottom. R19 denied pain anywhere and stated, I'm alright! The note further documented that the two staff lifted her back into her wheelchair and proceeded to lock her into place in the van. After returning to the facility, the LN assessed the resident and discovered two small skin tears on her left elbow and placed steri-strips (adhesive wound closures) over each skin tear. The skin tears were covered with a non-adherent dressing and wrapped with Kerlix (stretchy gauze bandage) to hold it in place.The EMR lacked documentation an investigation was completed for the 06/13/25 fall.On 12/02/25 at 09:50 AM, Certified Nurse Aide (CNA) N placed a gait belt around R19's waist. CNA N and CNA O assisted R19 to stand in front of her walker, and R19 walked to the bathroom.On 12/02/25 at 08:45 AM, CNA M stated R19 was a two-person assistance for transfers and ambulation. R19 had a recent fall, which scared her, and it made her feel more secure if staff walked with her.On 12/02/25 at 01:30 PM, Activity Z stated R19 did not have foot pedals on her wheelchair, and that made it more difficult to push her in her wheelchair because she had a habit of straightening out her legs when pushed. Activity Z further stated that she decided to go up the ramp backward, and when she started to pull R19 up the ramp, R19 started to slide out. Activity Z put her hand on R19's chest to try to hold her in the wheelchair, but she still slid out. Activity Z stated that it happened so fast that LN I did not get to her in time to stop the fall. Activity Z stated after the fall, she was reeducated on how to load residents into the facility van.On 12/03/25 at 09:30 AM, LN H stated R19 did not remember to use her call light and was a two-person assist with transfers. LN H further stated she has not had any recent falls.On 12/03/25 at 11:30 AM, Administrative Staff A verified that there was not a full investigation, including root cause analysis, on the fall, and R19 should have had foot pedals on her wheelchair.The facility's Abuse, Neglect, and Exploitation policy, dated 08/8/24, documented that the investigation was the process used to determine what happened. The designated facility personnel would begin the investigation immediately. A root cause investigation and analysis would be completed. The information gathered is given to the administration.

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide the required documentation or notification related to the resident's needs, appeal rights, or bed-hold policies. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents, with two residents reviewed for discharge. Based on observation, record review, and interview, the facility failed to provide Resident (R) 8 with written information regarding the facility bed hold policy when he was transferred to the hospital and the facility failed to complete a Recapulation (a required component of a residents comprehensive discharge summary from the facility, the form is completed to provide a concise summary of the residents entire stay to ensure continuity of care when transitioning to another care setting, home, or other providers) after R37 was discharged from the facility. Findings included:- R8's Electronic Medical Record (EMR) revealed diagnoses of congestive heart failure (CHF- a condition with low heart output and the body becomes congested with fluid), edema (swelling resulting from an excessive accumulation of fluid in the body tissues), gastroesophageal reflux (GERD- backflow of stomach contents to the esophagus), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). R8's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R8 had a Brief Interview for Mental Status (BIMS) score of nine, indicating moderately impaired cognition. The MDS recorded she required staff assistance with activities of daily living (ADL). The Fall Care Area Assessment (CAA) dated 01/24/25 recorded R8 required staff assistance with ADLs, mobility, and would ambulate without a device throughout the facility and in the room independently with a shuffling gait or with a gait belt and assist of staff as needed. The CAA documented the resident had moments of occasional confusion at times. R8's Care Plan dated 08/26/25 recorded R8 was able to feed himself with setup help and clean up assistance. The care plan documented staff would monitor R8 for targeted behavior symptoms, wandering, disrobing, inappropriate response to verbal communication, violence/aggression towards staff and others, and interventions effectiveness and document per facility protocol. On 06/21/25 at 04:37 AM the Nurse's Notes documented the resident woke up when kitchen staff arrived in the kitchenette and started making noises. R8 was shaking and pale, and an auxiliary (a body temperature reading taken from the armpit, normal range from 97.6 degrees Fahrenheit (F) to 99.4 degrees F) temperature was taken and was 100.4 degrees Fahrenheit (F). The nurses' notes indicated the resident was administered Tylenol (pain reliever and fever reducer medication), and staff placed lukewarm clothes on his face and neck during breathing treatment to help lower his temperature. On 06/21/25 at 05:21 AM the Nurse's Notes documented emergency medical personnel transferred the resident to the hospital for bilateral lower lung quadrant crackles and wheezing in the bilateral upper lung quadrant. The notes documented staff administered Tylenol and a breathing treatment at 04:31 AM, and the temperature rose to 100.4 degrees at 05:05 AM. The notes documented the resident's color was ash, and R8 was very anxious and had visible berating concerns. On 06/21/25 at 10:04 AM the Nurse's Notes documented the resident was admitted to the hospital for bilateral pneumonia (a lung infection that inflames the air sacks (alveoli), causing them to fill with fluid or pus, making it hard to breathe). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On 06/22/25 at 12:00 PM the Nurse's Notes documented the resident returned to the facility. R8's clinical record lacked a bed-hold policy. On 12/03/25 at 08:15 AM, Administrative Staff A verified the facility lacked evidence a signed bed hold policy was provided or signed by the resident's representative when R8 was transferred and admitted to the hospital on [DATE]. The facility's Bed Hold policy, dated 10/04/25, documented before the facility transfers a resident to a hospital or therapeutic leave, the facility would provide written information to the resident and/or resident representative that specifies: the duration of the state bed-hold policy during which the resident is permitted to return and resume residency in the facility; the reserve bed payment policy in the state plan; the facility's policies regarding bed-hold period, which are consistent with the law permitting the resident to return. The facility would allow the resident whose hospitalization or therapeutic leave exceeds the bed-hold policy under the state plan to return to the facility to the resident's previous room if available or immediately upon the first availability of a semi-private room if the resident requires the services provided by the facility and is eligible for Medicare Skilled Nursing Facility (SNF) services or Medicaid nursing facility services or pays privately for the services. Prior to transferring a resident to a hospital or allowing a resident to go on therapeutic leave, the facility nursing staff would provide written information to the resident and/or representative and family that specified: The duration of the bed hold policy under the State law and regulation, during which the resident is permitted to return and resume residence in the facility. The facility's policies regarding bed-hold periods. Signature proof of receipt of bed-hold policy. If the resident is transferred on an emergency basis, facility staff would provide the bed-hold policy to the resident/representative at the first opportunity, either in person by the facility at the hospital or other healthcare facility, or by registered mail, return receipt requested. If the signature is not returned to the facility within three calendar days, facility staff would call the resident /representative for phone confirmation of receipt and a reminder to return the form to the facility at the first possible opportunity, and phone confirmation of the receipt would be documented in the resident's clinical record. - The Electronic Medical Record (EMR) documented R37 was admitted to the facility on [DATE] with diagnoses of fracture of an unspecified part of the neck of the left femur (broken thigh bone), anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), and hypertension (high blood pressure). The admission Five-Day Minimum Data Set (MDS) dated [DATE] documented R37 had severely impaired cognition. R37 required substantial staff assistance with toileting hygiene, dressing, transfers, and partial staff assistance with personal hygiene and ambulation. (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	R37's 08/04/25 Care Plan documented the following interventions: 08/06/25 – R37 wished to return home with his wife. Encourage R37 to discuss feelings and concerns with impending discharge, and monitor for and address episodes of anxiety, fear, and distress. Evaluate and discuss with the resident, family, and caregivers the prognosis for independent or assisted living. Evaluate the resident's motivation to return to the community. Staff would make arrangements with the required community resources to support independence post-discharge with a home health service. Prepare and give the resident's daughter the contact numbers for all community referrals. The Nurse's Note dated 09/12/25 at 10:08 AM documented R37 was discharged to home with his daughter. R37's medication list was reviewed with his daughter; no medications were sent home, and they would be returned to the pharmacy. Review of R37's EMR lacked evidence of a completed discharge summary, which included a recapitulation of his stay. On 12/02/25 at 01:30 PM, Administrative Staff A stated the Director of Nursing would have completed the recapitulation but was unable to find one. The facility's Admission, Transfer and Discharge Policy, dated 09/24/25, stated the facility staff would document in the clinical record the reason for the discharge, treatments that were provided, diet, medication orders, and diagnoses. Staff would document a summary of the care and services that were provided, and the referrals given.

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that a nursing home area is free from accident hazards and provides adequate supervision to prevent accidents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** The facility had a census of 32 residents. The sample included 12 residents, with nine reviewed for accidents. Based on observation, interview, and record review, the facility failed to ensure a safe environment to prevent falls for three sampled residents: Resident (R) 19, who fell out of her wheelchair; R26, who had an unwitnessed fall in his room; and R3, when staff failed to place her alarm on her wheelchair, and she fell.Findings included:- R3's Electronic Medical Record (EMR) documented the resident had diagnoses of rheumatoid arthritis (chronic inflammatory disease that affects joints and other organ systems), peripheral vascular disease (PVD- slow and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), atrial fibrillation (rapid, irregular heartbeat), fracture of right femur (a break in the femur-thigh bone), and fractured right humerus (upper arm bone). R3's admission Minimum Data Set (MDS) dated [DATE] recorded R3 had a Brief Interview for Mental Status (BIMS) of five, indicating severely impaired cognition. The MDS recorded the resident used a cane or wheelchair for mobility and required substantial to maximal assistance with sit-to-stand, chair/bed to chair transfer, toilet transfer, with supervision or touching assistance to walk ten feet once standing. The MDS documented the resident had a bed and a chair alarm that was used daily. The MDS documented the resident had a fall in the last two to six months prior to admission and had a fall in the last month prior to admission. R3's Fall Care Area Assessment (CAA) dated 09/18/25 documented R3 had fallen at home and sustained a right femur fracture, right humerus fracture, and fracture of the superior rim of the left pubis (a pair of bones forming the two sides of the pelvis). The CAA documented R3 required staff assistance with dressing and grooming due to her immobilized arm, with physical therapy and occupational evaluations scheduled to guide her care plan and mobility goals. Currently, R3 uses a gait belt with a walker for pivot transfers or short distances. R3's Physical Restraint CAA dated 09/18/25 documented the resident does not have a physical restraint. R3's Fall Care Plan dated 09/21/25 documented R3 was a high fall risk, related to deconditioning, gait/balance problems, and multiple fractures. The care plan documented staff would ensure the resident's call light was within reach and encourage the resident to use it, and documented staff would ensure a prompt response to all requests for assistance. The plan of care documented staff would remind the resident to call for assistance, and staff would determine the root cause of the resident's past falls. The care plan documented staff would ensure a safe environment with even floors free from spills and/or clutter, adequate, glare-free light, a working and reachable call light, the bed in low position at night, personal items within reach, and alarms on bed and chair. R3's Activities of Daily Living (ADL) Care Plan dated 09/21/25 directed one staff to assist R3 with a quad cane and assist of one staff. The ADL care plan documented staff would encourage the resident to use the bell to call for assistance. R3' EMR lacked a Fall Risk Assessment. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurses Note dated 10/17/25 at 09:05 PM documented R3 was found on the floor in her room. Observation revealed R3's pull tab alarm was not attached according to Certified Nurse Aide (CNA) P, who stated she thought the resident had a pressure alarm in her chair. R3 stated she was on her way back from the bathroom when she fell, hit her elbow, and sustained a skin tear, approximately 0.5 centimeters (cm) by 0.5 cm, on her right elbow. The medication aide cleansed the area and applied a gauze wrap, while the resident complained of a dull, achy pain in her right shoulder. The nurse obtained vital signs, neuros were intact, pain medication was administered, and then the resident rested in her bed. The resident was re-educated about using the call light when she got up to use the restroom. The Fall Investigation Report dated 10/18/25 documented R3 was new to the facility, very independent, did not like to ask staff for help, and did not remember to ask for help. The investigation documented staff would ensure the alarm was in place and functioning, and staff would ensure R3 would be taken to the bathroom at normal intervals. The investigation documented R3's bed/chair alarm was off, and the environment had poor lighting when the fall occurred. On 12/02/25 at 11:35 AM, observation revealed R3 transferred herself from her wheelchair to a chair at the dining room chair which activated the TABS alarm the resident had on the wheelchair and it was attached to her right shoulder. Licensed Nurse (LN) G approached R3 and silenced the wheelchair alarm and attached the alarm to the device the resident had on the dining room chair. On 12/02/25 at 09:00 AM, LN G verified R3 would frequently get up and transfer from her wheelchair to the chair and from her wheelchair to her recliner in her room. LN G stated staff reminded the resident, but it continued to happen, and R3 has had a fall at the facility, but no significant injury that she was aware of. On 12/02/25 at 08:15 AM, Administrative Staff A stated the medical records documented the resident had a fall on 10/17/25 at 09:05 PM, and after investigation, it was determined R3 did not have the TABS alarm in place, and the aide thought the resident had a pressure pad alarm in her wheelchair. R3 sustained a fall with a skin tear to her right elbow. Administrative Staff A verified the staff are trained upon hire regarding falls and fall prevention, and they were to follow the resident's individualized care plan. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Fall Prevention Program policy, dated 09/24/25, documented reach resident that resided in the facility would be provided services and care that ensured the residents' environment remained as free from accident hazards as possible and each resident received adequate supervision and assistive devices to prevent accidents. Every resident would be assessed for the causal risk factors for falling at the time of admission, upon return from a healthcare facility, and after every fall in the facility. On the day of admission, each resident would be assessed for falls by a licensed nurse. The initial care plan and communication tool would be used to identify activities or habits that place the resident at risk for falls. The resident would be instructed about safety measures and rationale, including to call for assistance before getting out o bed, raise slowly, keep necessary items within reach, and the proper use of canes, walkers, wheelchairs and crutches. The interdisciplinary team would develop a plan for services to improve of maintain the resident's standing and sitting balance and other interventions to reduce the elder's risk for falls. The plan would include specific, individualized information about the resident's routine and personal habits that may place the resident at risk for falls such as nighttime voiding or nighttime wandering. Every time the resident returns from a stay in another health care facility, a nurse would re-assess the resident to determine if the risk for falls increased/changed. The care plan would be reviewed and amended based on the re-assessment. - The Electronic Medical Record (EMR) for R19 documented diagnoses of hypertension (high blood pressure), transient ischemic attack (TIA- a temporary episode of inadequate blood supply to the brain), and chronic kidney disease (a long-term condition where your kidneys become damaged and can't filter waste and extra fluid from the blood). The Annal Minimum Data Set (MDS) dated [DATE] documented R19 had intact cognition. R19 was dependent upon staff for toileting hygiene, showers, and lower-body dressing. R19 required substantial staff assistance for oral hygiene, upper body dressing, personal hygiene, mobility, and transfers. R19 had upper functional impairment on both sides and had one fall with injury. R19's Quarterly MDS dated 09/10/25 documented R19 had severely impaired cognition. R19 required substantial staff assistance for showers, dressing, personal hygiene, mobility, transfers, and partial staff assistance for ambulation. R19 had upper functional impairment on both sides and had no falls. The Fall Risk Assessment dated 03/23/25, 06/18/25, and 09/08/25 documented R19 was a high risk for falls. R19's 09/04/25 Care Plan included the following interventions: 05/17/24 – Use a gait belt with all transfers. 09/15/24 - Ensure R19 had socks and shoes on with transfers and ambulation during the day. 11/30/24 – Use a wheelchair instead of ambulating when weak. 06/13/25 – Reeducate Licensed Nurse (LN) and Activity Director (AD) on how to load R19 into the facility van and to have foot pedals on her wheelchair. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Nurse's Note dated 06/13/25 at 03:57 PM (late entry) documented while leaving the museum, LN I and Activity Z loaded R19 into the wheelchair van, pulled her up the ramp, which had the resident tilt forward. R19 slowly slipped forward out of the chair and slid to the ramp on her bottom. R19 denied pain anywhere and stated, I'm alright! The note further documented that the two staff lifted her back into her wheelchair and proceeded to lock her into place in the van. After returning to the facility, the LN assessed the resident and discovered two small skin tears on her left elbow and placed steri-strips (adhesive wound closures) over each skin tear. The skin tears were covered with a non-adherent dressing and wrapped with Kerlix (stretchy gauze bandage) to hold it in place. The EMR lacked documentation an investigation was completed for the 06/13/25 fall. On 12/02/25 at 09:50 AM, Certified Nurse Aide (CNA) N placed a gait belt around R19's waist. CNA N and CNA O assisted R19 to stand in front of her walker, and R19 walked to the bathroom. On 12/02/25 at 08:45 AM, CNA M stated R19 was a two-person assistance for transfers and ambulation. R19 had a recent fall, which scared her, and it made her feel more secure if staff walked with her. On 12/02/25 at 01:30 PM, Activity Z stated R19 did not have foot pedals on her wheelchair, and that made it more difficult to push her in her wheelchair because she had a habit of straightening out her legs when she was pushed. Activity Z further stated that she decided to go up the ramp backward, and when she started to pull R19 up the ramp, R19 started to slide out. Activity Z put her hand on R19's chest to try to hold her in the wheelchair, but she still slid out. Activity Z stated that it happened so fast that LN I did not get to her in time to stop the fall. Activity Z stated that after the fall, she was reeducated on how to load residents into the facility van. On 12/03/25 at 09:30 AM, LN H stated R19 did not remember to use her call light and was a two-person assist with transfers. LN H further stated she has not had any recent falls. On 12/03/25 at 11:30 AM, Administrative Staff A verified that there was not a full investigation, including root cause analysis, on the fall, and R19 should have had foot pedals on her wheelchair. The facility's Fall Prevention Protocol, dated 09/24/25, documented that each elder residing at the facility would be provided services and care that ensured that the elder's environment remained as free from accident hazards as possible and each elder received adequate supervision and assistive devices to prevent accidents. Every elder would be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility, and after every fall in the facility. - The Electronic Medical Record (EMR) for R26 documented diagnoses of osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), hypertension (high blood pressure), and falls. The Quarterly Minimum Data Set (MDS) dated [DATE] documented R26 had intact cognition. R26 required partial staff assistance for toileting hygiene, dressing, mobility, transfers, and ambulation. R26 had lower functional impairment on one side and had no falls. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Quarterly MDS dated 09/17/25 documented R26 had intact cognition. R26 required partial staff assistance for toileting hygiene, dressing, mobility, transfers, and ambulation. R26 had lower functional impairment on one side and had one fall with injury. The Fall Risk Assessments dated 01/06/25, 03/31/25, 06/24/25, and 09/16/25 documented R26 was a moderate risk for falls. R26's 09/11/25 Care Plan included the following interventions: 04/19/24 – Ensure R26 wore appropriate footwear when ambulated or while in a wheelchair. Ensure R26's call light is in reach and encourage him to use it. Encourage R26 to participate in activities that promote exercise, physical activity for strengthening, and improved mobility. 01/05/25 – Encourage R26 to sit down on the bath chair before taking his shoes off for bathing. 01/09/25 – Assist R26 to use the hall bathroom when he needs to use the bathroom, and his bathroom is in use. 01/19/25 – R26 to use a sit-to-stand mechanical lift (a medical device that helps individuals with partial mobility move safely from a seated to a standing position, or transfer between chairs, bed, and commodes) and wheelchair with no ambulation as his legs give out. This intervention was discontinued on 01/20/25. 01/20/25 – Ambulate R26 with the assistance of two staff and his wheelchair behind him in case of falls. R26's plan of care lacked an intervention after his fall on 01/27/25. The Nurse's Notes dated 01/27/25 documented R26 was lowered to the floor by staff while being assisted to the bathroom. Then R26 dropped himself to the floor on the way back to his bed. No injuries observed, and his vital signs were within normal range. The EMR lacked documentation an investigation was completed for the 01/27/25 fall. On 12/02/25 at 08:45 AM, Certified Nurse Aide (CNA) M placed a gait belt around R26's waist, R26 stood up in front of his walker, and walked with him down the hall. CNA M stated R26 had not had a fall in a long time, and staff were to use a gait belt when he was ambulated. CNA M further stated, he had falls in the past because he did not like to use his call light and would get up on his own. On 12/03/25 at 09:30 AM, Licensed Nurse (LN) H stated, she preferred to use the sit-to-stand lift with R26, but would expect there to be at least two staff with him for transfers and ambulation. On 12/03/05 at 08:55 AM, Administrative Staff A stated there should have been an investigation with root cause analysis for the fall, but was unable to find one. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The facility's Fall Prevention Protocol, dated 09/24/25, documented that each elder residing at the facility would be provided services and care that ensured that the elder's environment remained as free from accident hazards as possible and each elder received adequate supervision and assistive devices to prevent accidents. Every elder would be assessed for the causal risk factors for falling at the time of admission, upon return from a health care facility, and after every fall in the facility.

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F 0727 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Have a registered nurse on duty 8 hours a day; and select a registered nurse to be the director of nurses on a full time basis. The facility had a census of 32 residents. The sample included 12 residents. Based on interviews and record review, the facility failed to provide Registered Nurse (RN) coverage for eight consecutive hours a day, seven days a week. This placed all residents who reside at the facility at risk for decreased quality of care. Findings included:- The Payroll Based Journal (PBJ- a required detail of staffing information submitted by nursing homes to the Centers of Medicare and Medicaid Services [CMS]) documented that the facility lacked RN eight-hour coverage for the following days: 04/06/25, 04/07/25, 04/13/25, 04/19/25, 04/20/25, 04/26/25, 04/27/25, 05/03/25, 05/04/25, 05/17/25, 05/18/25, 05/2425, 05/25/25, 05/31/25, 06/01/25, 06/07/25, 06/13/25, 06/15/25, 06/21/25, and 06/22/25.The Nursing Schedule, dated November 2025, documented that the facility lacked RN eight-hour coverage for the following days: 11/08/25, 11/09/25, 11/22/25, and 11/23/25. The Nursing Schedule, dated December 2025, ldocumented that the facility lacked RN eight-hour coverage for the following days: 12/01/25 and 12/02/25.On 12/02/25 at 09:45 AM, Administrative Staff A verified the above dates as days they did not have an RN in the building. Administrative Staff A stated that it was hard to find Registered Nurses since they are out in the country.The facility's Registered Nurse policy, dated 08/06/24, documented that the facility would employ services of a Registered Nurse for at least eight consecutive hours a day, seven days a week. The facility would designate a Registered Nurse to serve as the Director of Nursing on a full-time basis. The DON may serve as a charge nurse only when the facility has an average daily census of sixty or fewer residents.

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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. (continued on next page)

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F 0756 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 32 residents. The sample included 12 residents, with five reviewed for unnecessary medications. Based on observation, interview, and record review, the facility failed to ensure the Consultant Pharmacist identified and reported to the Director of Nursing, facility medical director, and physician, the lack of a 14-day stop date or specified duration, for Resident (R) 32's as needed (PRN) antianxiety (class of medications that calm and relax people) medication. Findings included:- R32's Electronic Medical Record (EMR) revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), dementia (progressive mental disorder characterized by failing memory, confusion), and major depressive disorder (major mood disorder that causes persistent feelings of sadness). R32's Quarterly Minimum Data Set (MDS) dated [DATE] recorded R32 had severely impaired cognition. The MDS recorded he required extensive assistance from staff with activities of daily living (ADL). The MDS documented R32 received an antianxiety medication during the observation period.R32's Care Plan dated 08/07/25 recorded R32 required one staff assistance with most activities of daily living (ADL) care. R32's care plan documented the resident had a mood problem related to depressive disorder and anxiety with physical and verbal aggression and resistance to cares. The care plan documented the resident received a mental health consult monthly and as needed, and staff would administer medications as ordered and document for side effects and effectiveness.R32's Physician's Order dated 03/25/25 directed the staff to administer Ativan (lorazepam- antianxiety medication) cream 1.0 milligram (mg)/per milliliter (ml), every six hours as needed for anxiety/aggression related to anxiety disorder. The order lacked a stop date.R32's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN lorazepam.The Consultant Pharmacist's monthly review for R32, completed on 11/13/25, lacked evidence the Consultant Pharmacist identified the PRN lorazepam with no stop dateOn 12/01/25 at 12:30 PM, R32 sat in a wheelchair in the Pod three hallway. Continued observation revealed the resident went to the partially opened equipment door, touched the door handle, then propelled down the hall to East exit door. Continued observation revealed the resident went to the East exit door and tried to grab at the door frame and was unable to open the door, then turned around and started propelling back down the hall to Pod three. On 12/01/25 at 12:40 PM, Certified Medication Aide (CMA) S verified the resident had received Ativan cream to her wrist approximately 20 minutes ago and stated R32 had been agitated and staff were not able to redirect her, so the nurse administered the Ativan cream to R32's wrist. CMA S verified the medication takes approximately one hour to kick in.On 12/03/25 at 08:15 AM, Administrative Staff A verified the resident received Ativan cream PRN, with a physician order date of 03/25/25. Administrative Staff A verified the facility failed to obtain the 14-day stop date or a reason for the continued use with the appropriate rationale. Administrative Staff A verified the Consultant Pharmacist had sent monthly reviews to the facility and lacked a recommendation for the 14-day stop date or a rationale for continued use of the medication. The Antipsychotic Medication Use policy dated 09/26/25 recorded antipsychotic medication would be prescribed when indicated by assessment and medical necessity and after other non-pharmacological interventions or alternatives had been considered or used, and at the lowest effective therapeutic dose for the shortest effective duration. The policy stated each resident who had an order for an antipsychotic medication would be assessed and periodically reassessed during their stay to determine the effectiveness of the medication. The facility's Pharmacy Services policy dated 09/28/24 documented the facility would provide pharmacy services in accordance with State and Federal regulations. The facility would employ or obtain services of a licensed pharmacist who would provide consultation on all aspects of the provision of pharmacy services in the facility, establish a system of records and receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation, determine that drug records are in order and that an account of all controlled drugs are maintained and periodically reconciled. The facility would provide pharmaceutical services, including procedures that assured the accurate acquisition, receiving, dispensing, and administration of all drugs and biologicals to meet the needs of each resident.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. The facility had a census of 32 residents. The sample included 12 residents. Based on observation, interview, and record review, the facility failed to store and label biologicals adequately when staff failed to date one insulin (medications used to treat high blood glucose levels) pen when opened and failed to remove or dispose of one expired bottle of stock medications. Findings included:- On 12/01/25 at 10:56 AM, observation of Pod one medication room refrigerator revealed the following: R7's opened insulin glargine (long-acting insulin) pen without an open date or a discard date.On 12/01/25 at 11:05 AM, observation of Pod one medication cart revealed the following:One expired stock medication bottle:Thera High Potency Vitamin Dietary Supplement, 160 count bottle, expired June 2025, and the facility had dated the bottle on 10/26/25 when they placed the medication in the medication cart for use.On 12/01/25 at 11:10 AM, Licensed Nurse (LN) G verified the expiration date on the stock medication and the undated insulin pen. LN G verified staff were to date the insulin pens when opened and discard expired medications.On 12/03/25 at 8:15 AM, Administrative Staff A verified the medications should be discarded when the bottle has an expired date, and the insulin pens should be dated when opened and dated with an expiration date.The facility's Medication Administration policy, dated 08/29/24, stated all medications would be administered to every resident as ordered by the physician in a safe and sanitary manner. The policy documented prior to administering or removing floor stock, the dispensing pharmacist would review all medication orders or prescriptions unless a delay in administration would harm the resident in an urgent situation, including a sudden change in the resident's clinical status.The facility's Pharmacy Services policy, dated 09/28/24, stated drugs and biologicals used in the facility would be labeled in accordance with current accepted professional principles and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. The policy stated the facility would provide pharmaceutical services, including procedures that assured the accurate acquisition, receiving, and administration of all drugs and biologicals to meet the needs of each resident.

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. The facility had a census of 32 residents. The sample included 12 residents. Based on observation, record review, and interview, the facility failed to store food by professional standards for food service safety in two kitchenettes and one pantry room.Findings included:- On 12/01/25 at 08:30 AM, the silver upright refrigerator located in Pod two kitchenette had the following:One large gallon zip-lock bag of potato salad, undated.One plastic bag of chicken patties, 16 count, undated.One plastic bag of chicken patties, six count, undated.One plastic bag of pancakes, three count, undated.On 12/01/25 at 08:40 AM, the silver upright refrigerator located in Pod three kitchenette, had the following:One large bowl, approximately 32 ounces (oz) of vegetable beef soup, undated.One covered plastic bowl, approximately 6 inches by 6 inches of cranberries, undated. One 32-oz plastic container of strawberry yogurt, undated.On 12/01/25 at 09:00 AM, observation of the pantry room two door silver upright refrigerated on the North Administration Hall upon entrance to the facility, had the following:Two plastic bags, approximately 16 oz of shredded American cheese, undated.One plastic bag of sliced Swiss cheese, approximately 160 slices, undated.Two plastic bags of chicken tenders, undated.One plastic bag of diced chicken, undated.On 12/01/25 at 09:05 AM, during the initial kitchenette tour in Pod one, Pod two, and Pod three, revealed the facility lacked and had failed to take daily temperature logs for the dishwashers since moving into the new facility in February 2025. On 12/01/25 at 9:10 AM, Administrative Staff A verified the above findings and stated staff should label and dated food items before placing them in the refrigerator or freezer. Administrative Staff A verified when the dishwashers were installed in the newly built facility and the manufacture representative informed them, they did not need to worry about the temperature of the dishwashers because the dish products they were using were a low temperature dishwasher detergent that would properly sanitize the dishes and silverware, so facility staff did not feel there was a need to document the water temperatures. The facility's Dietary Purchases, Receipt and Storage policy, dated 11/14/24, documented food and nonfood supplies would be purchased, received, and stored under sanitary, safe, and secure conditions as required to meet federal, state, and local laws. The Dining Service Manager would be responsible for receiving and storage of all food and supplies in a proper area. All products would be labeled with the date received in the facility, and all food would be rotated so that the first in would be the first out. All unlabeled, rusty, broken containers or cans with side dents or rim dents would be removed, marked unacceptable, and destroyed. The facility's Dietary Cleaning Procedure policy, dated 11/14/24, documented the facility would store, prepare, and serve food under sanitary conditions to ensure that proper sanitization and food handling practices to prevent the outbreak of foodborne illnesses are attained continuously. The policy documented the evening staff members would check the dates on containers of leftovers and dispose of food found to have been refrigerated for more than three days. The daily, weekly, and monthly cleaning schedule would be developed by the Certified Dietary Manager based on the needs of the residents and activities that occur in the kitchen and dining rooms.

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F 0851 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Electronically submit to CMS complete and accurate direct care staffing information, based on payroll and other verifiable and auditable data. The facility had a census of 32 residents. Based on observation, interview, and record review, the facility failed to submit complete and accurate staffing information through Payroll Based Journaling (PBJ). Findings included:- The PBJ report provided by the Centers for Medicare & Medicaid Services (CMS) for Medicare & Medicaid Services (CMS) for Fiscal Year (FY) 2024 Quarter (Q) 4 indicated no licensed nurse coverage on five dates.Review of the facility's licensed nurse payroll data for the dates listed above revealed a licensed nurse was on duty for 24 hours a day, seven days a week.On 12/02/25 at 09:45 AM, Administrative Staff A stated they have had problems with the PBJ in the past, but never were without a nurse in the building. Administrative Staff A stated that the dates that say there was not a nurse in the building were probably due to the use of agency nurse's and it was not documented.The facility's Mandatory Submission of Uniform Format Staffing Information (PBJ) policy, dated 09/08/25, documented the facility's complete submission of staffing based on payroll data in a uniform format as specified by regulatory requirements. The facility would electronically submit to CMS complete and accurate direct care staffing information, including information for agency and contract staff, based on payroll and other verifiable and auditable data in a uniform format according to specifications established by the Centers for Medicare and Medicaid Services.