STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175492	A. Building B. Wing	04/15/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Park Villa	114 S High St Clyde, KS 66938

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 0801 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Employ sufficient staff with the appropriate competencies and skills sets to carry out the functions of the food and nutrition service, including a qualified dietician. Based on observation, record review, and interview, the facility failed to employ a full-time certified dietary manager for the 31 residents who resided in the facility and received meals from the facility kitchen. Findings included: - 04/14/26, a review of the noon meal consisted of shrimp, cornbread, cooked sliced squash, rice, and yellow cake with chocolate frosting. On 04/14/26 at 11:15 AM, observation revealed Dietary Staff (DS) BB in the kitchen overseeing the preparation of the noon meal. On 04/13/26 at 10:56 AM, DS BB verified she was not a Certified Dietary Manager (CDM). DS BB stated she had enrolled in the classes but had not completed them 04/15/26 at 11:45 AM, Administrative Nurse D verified DS BB had no dietary manager certification, but had enrolled and started the dietary certification classes. The facility's Nutritional Services Policy, revised 01/21/26, documented the certified dietary manager would oversee all kitchen procedures, including the following:1. Menu planning2. Diet and diet manual with nutritional evaluations3. Office procedures, including the process of nursing staff informing the Registered Dietitian, in writing, of the arrival of new elders.4, Food production5, Food service

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

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

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F 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. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to store, distribute, and serve food by professional standards for food service safety in the facility's kitchen. The facility failed to label, seal, and date food stored in the refrigerator/freezer and dry storage area. The facility also failed to consistently log freezer/refrigerator temperatures. Findings included:- On 04/13/26 at 08:10 AM, observation in the kitchen revealed the following:A white upright freezer had approximately one-quarter inch (in) of ice built up along the inside of the freezer and the shelves.The refrigerator located in the kitchen had a plastic bag with unlabeled, undated sliced yellow cheese.The March 2026 Freezer/Refrigerator Temperature Logs lacked documentation of the readings for the following freezers and refrigerators in the morning and evening:1. Chest freezer located in dry storage on 05,06,10,11,14,15,17,19,21, and 23-31.2. A white stand-up freezer on 7,8,14, 15,18, 21, and 25.3. A double door refrigerator on 7,8,15, 18, 21, 22.4. A single door refrigerator on 6, 7, 8, 21.The April freezer/refrigerator temperature logs lacked documentation of the readings for the following freezers and refrigerators in the morning and evening:A double door freezer on 4, 5,The ice machine located in the area between the kitchen and storage room had a plastic lid and a metal object on the floor behind it, and a plastic green drinking cup sitting on top of the drain underneath it.Eight 15.5-pound (lb.) plastic jugs of used cooking grease with numerous different sizes of grayish-black substances on their top.The dry storage area had the following:An approximately one-quarter full 5 lb. package of undated pasta Labello egg noodles.An approximately one-quarter full 4.5 lb. package of unlabeled, undated, unsealed [NAME] noodles. Approximately three-quarters of a full package of undated strawberry gelatin.An approximately three-quarters full bag of unsealed buttermilk pancake.On 04/13/26 at 08:20 AM, Dietary Staff (DS) CC verified the above findings and stated she would ask the dietary manager what to do with the findings when she arrived at the facility for her shift.On 04/14/26 at 01:30 PM, the Dietary Manager (DM) BB stated staff should label and date all food placed in dry storage, refrigerator, or freezer, when received, and if open, make sure they are sealed, labeled, and dated with the open date.The facility's Dietary Purchases, Receipt and Storage Policy, revised 01/21/26, documented all products would be labeled with the date received in the facility. Frozen foods stored in the freezer, and the temperature would be maintained at 0 to -10 degrees Fahrenheit (F). Produce is stored in the refrigerator, and the temperature would be maintained at 38-44 degrees F. Dairy products would be stored in the refrigerator, and the temperature would be maintained at 35 to 40 degrees F. The facility's Monitoring of Refrigerators and Freezers Policy, revised 01/21/26, documented all refrigerators/freezers would be cleaned on a weekly basis and as necessary for spills. Refrigerators that are accessible to elders and used by multiple elders and/ or families would contain only food that is sealed in an airtight container that had not been inside an elder's room. All food items would be labeled with the contents of the container and the date it was placed in the refrigerator. A temperature log would be completed. The Certified Dietary Manager/designee is responsible for monitoring temperatures and appropriate logging of temperatures, and appropriate discarding from refrigerators/freezers containing food items. All temperature logs will be maintained in the environmental services office for two weeks.

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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 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate pressure ulcer care and prevent new ulcers from developing. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to initiate timely interventions to prevent the development of a Stage 2 pressure ulcer (localized injury to the skin and/or underlying tissue usually over a bony prominence, as a result of pressure, or pressure in combination with shear and/or friction) for Resident (R) 27. Findings included:- R27's Electronic Health Record (EHR) revealed a diagnosis of diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), osteoarthritis (degenerative changes to one or many joints characterized by swelling and pain), heart failure, and muscle weakness. R27's Significant Change Minimum Date Set (MDS), dated [DATE], recorded R27 had a Brief Interview for Mental Status (BIMS) score of five, indicating severely impaired cognition. The assessment revealed R27 required extensive staff assistance of two for bed mobility, personal hygiene, dressing, repositioning, and transfers. The resident was at risk for pressure ulcer development, had one or more unhealed pressure ulcers/injuries but did not document the number of Stage one, two, three or four pressure ulcers. The MDS documented that the resident had a moisture associated skin damage area with a pressure reducing device in her chair, was on a turning/repositioning program, with nutritional or hydration intervention to manage skin problems. R27's Care Plan dated 02/11/26, documented R27 had potential for skin impairment due to a history of refusal to lay down and get pressure off buttocks and had fragile skin. The CAA documented staff would encourage R27 to lay down in bed before and between meals and reposition at least every two hours and as necessary. R27's activities of daily living (ADL) Care Plan dated 02/11/26, recorded R27 required extensive assistance of one to two staff with most ADLs. R27's urinary incontinence Care Plan dated 02/11/26 recorded R27 had a urinary catheter due to constant urinary retention and incontinence. The Braden Scale for Predicting Pressure Ulcer Risk assessment dated [DATE], documented a score of 16, which indicated the resident was at risk for pressure ulcer development.The Weekly Wound assessment dated [DATE], documented R27 had a lateral opening on her left buttocks with a measurement of 2.0 centimeters by 1.0 cm, and the area was cleansed, dried, and dressings were applied. The Plan of Care Note, dated 01/29/26 at 10:17 AM, documented R27 had a wound and weight loss; the note documented the resident had a catheter placed to aid in wound healing. The note documented that staff switched out R27's old recliner chair due to the seat being worn out and replaced the chair with a new recliner. The Weekly Wound Assessment dated 04/14/26, documented R27 had left inner buttocks wound with a measurement of 3.0 cm by 2.0 cm by 0.5 cm depth. The area was cleansed, dried and Prisma (a sterile wound dressing made of cellulose, collagen, and zinc promotes an antibacterial environment to promote wound healing) applied to the wound bed then covered with a dressing. No new skin concerns were noted at the time. Review of R27's medical record revealed a physician order dated 04/14/26 which directed staff to cleanse the open areas on R27's bottom with wound cleanser, apply saline moistened Prisma to the wound bed and cover with ABD daily. On 04/14/26 at 08:50 AM, observation revealed R27 lying on the left side of the bed and Certified Nurse Aide (CNA) N assisted Licensed Nurse (LN) G to keep R27 turned on her side while she performed wound care. LN G cleansed the buttocks wound on the left inner buttocks with soap and water, then wiped with saline solution and placed a cut to fit Prisma wound dressing and covered with an ABD pad, no drainage noted. LN G measured R27's wound at 2.0 cm x 3.5 cm by 0.8 cm depth. On 04/15/26 at 10:45 AM, Administrative Nurse E verified R27's pressure ulcer was facility acquired and stated she developed it after R27 sustained a left 5th metatarsal fracture and had to wear a walking boot. The resident is not as mobile and incontinent and did not want to sleep in her bed and sit in the recliner and wheelchair. The facility's Wound Assessment, Prevention and Treatment policy dated 01/19/26, documented all residents considered to have some risk of the development of pressure ulcers. A licensed nurse will perform a full body skin assessment on admission within two to four hours of entrance to the facility and again on the (continued on next page)

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F 0686 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	last day of the assessment period. A skin assessment utilizes the Braden scale and skin assessment criteria described in the skin assessment policy. A skin assessment would be performed on the day of return from a stay in another health care facility and seven days after that return, and each time a change in the resident's condition is noted. Braden Scale would be performed weekly for four weeks following an admission. After conducting an inspection of the resident's skin, the nurse would review the resident's assessment protocol for pressure ulcers to identify risk factors for the development of pressure ulcers. An immediate plan to reduce a resident's risk of pressure ulcers or to treat an existing pressure ulcer would be implemented. The Certified Nurse Aide would perform a skin assessment at the time of each bathing experience document and report findings to the licensed nurse. Residents with lower extremities with ulcers would be assessed by a physician to determine the etiology of the ulcer. The physician's diagnosis would be recorded in the resident's clinical record.

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F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. Based on observation, interview, and record review, the facility failed to discard expired stock medication from the North Hall medication cart. Findings included: - On 04/13/2026 at 08:10 AM, observation of the North Hall medication cart revealed the following:Acetaminophen suppositories 650 milligrams (mg), four suppositories, expiration 3/2026. On 04/13/2026 at 08:15 AM, Certified Medication Aide (CMA) R verified the medication aides or nurses were to discard expired medications. On 4/15/2026 at 02:30 PM, Administrative Nurse E verified the medication aides or nurses were to check the medication cart and discard expired medications. The facility's Medication Labeling and Storage policy, dated 01/22/2026, documented medications are labeled and stored in accordance with facility requirements and State and Federal laws. All drug containers would be labeled, and drug labels must be clear, consistent, legible, and in compliance with State and Federal requirements. Floor stock medications are labeled floor stock or house supply and kept in the original manufacturer's container with the expiration date and lot number clearly evident.

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Arrange for the provision of hospice services or assist the resident in transferring to a facility that will arrange for the provision of hospice services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure a coordinated plan of care, which coordinated care and services provided by the facility with the care and services provided by hospice (a type of health care that focused on the terminally ill patient's pain and symptoms and attending to their emotional and spiritual needs at the end of life), was developed and available for Resident (R)12 and R5. This placed R12 and R5 at risk for inappropriate end of life cares. Findings included:- R12's Electronic Health Record (EHR) revealed diagnosis of Alzheimer's (progressive mental deterioration characterized by confusion and memory failure), coronary artery disease (CAD- abnormal condition that may affect the flow of oxygen to the heart), and atrial fibrillation (rapid, irregular heartbeat). R12's Significant Change Minimum Data Set (MDS), dated [DATE], recorded R12 had severely impaired cognition. The MDS recorded he required extensive assistance of two staff with bed mobility and transfers. The MDS documented R12 received hospice services. R12's Care Plan, dated 01/19/26, recorded R12 required extensive assistance with most activities of daily living (ADL) care. R12's Care Plan documented R12 had a terminal prognosis due to Alzheimer's and directed staff to adjust provision of ADLs to compensate for R12's change in abilities and consult with the physician to have hospice care in the facility. The care plan directed the staff to observe R12 closely for signs of pain, administer pain medications ordered and notify the physician if there is breakthrough pain. The care plan lacked instruction on the services provided by hospice, including hospice staff visits, supplies, and medical equipment provided by hospice, and medications covered by hospice. Review of R12's medical records revealed the resident was admitted to hospice care on 12/29/25 but lacked evidence of coordination of care between hospice and the facility. On 04/14/26 at 09:30 AM, R12 was lying in a low bed and Certified Medication Aide (CMA) R knelt beside R12's bed and administered his eye drops. On 04/13/26 at 02:00 PM, Administrative Nurse F verified the facility lacked specific information on the facility care plan that coordinated with the hospice care plan. The Hospice Services policy, dated 01/22/26, documented the facility would provide continuity of care to provide residents who are terminally ill with the opportunity to receive comprehensive, interdisciplinary care that would recognize spiritual needs and assist residents, family members, and friends to live as fully and completely as possible with meaning and dignity. An interdisciplinary care plan would integrate the care and services provided by the facility and the hospice provider to include residents, staff, and physician comfort with dealing with pain. The care plan would also include family expectations, resident and family knowledge of disease progression and eventual outcome, staff time required to provide care and services, cultural and ethnic diversity, and communication and/or coordination of participants and agencies providing aspects of palliative care. The facility would coordinate care planning with the hospice provider, including all services and supplies provided by the hospice provider. - R5s Electronic Health Record (EHR) revealed diagnosis of peripheral vascular disease (PVD- slow (continued on next page)

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F 0849 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	and progressive circulation disorder causing narrowing, blockage, or spasms in a blood vessel), diabetes (DM-when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin, hypertension (HTN-elevated blood pressure), atherosclerotic heart disease(a disease involving the buildup of fats, cholesterol, and other substances in artery walls, which narrows pathways and restricts blood flow). R5's Significant Change Minimum Data Set (MDS), revised 03/10/26, documented R5 had a Brief Interview of Mental Status (BIMS) score of two, which indicated severe cognitive impairment. The MDS document R5, dependent on staff with putting on and taking off footwear, required substantial, maximal staff assist with oral and toileting hygiene, bed mobility, transfers, upper and lower body dressing, and partial, moderate assist with personal hygiene. The MDS documented R5 received hospice care services. R's Care Plan, revised 07/09/25, documented R5 required moderate to extensive assistance with activities of daily living (ADLs). R5's Care Plan documented that the resident was admitted [hospice services] on 03/10/26. The plan directed the staff to adjust the provision of R5's activities of daily living to compensate for R5's changing abilities and encourage R5 to participate to the extent she wishes to participate. The plan directed staff to assess R5 for coping strategies, respect her wishes, and consult with the physician and services to have continuing hospice care for R5 in the facility. The plan directed staff to monitor R5 closely for signs of pain, administer pain medications as ordered, and notify the physician and hospice immediately if there is breakthrough pain. The care plan lacked a contact number for hospice, what supplies, equipment, and medications hospice would provide, when hospice staff would be in the building, and what care they would provide. A review of R5's clinical record revealed the resident was admitted to hospice care on 03/10/26. On 04/15/26 at 08:10 AM, R5 rested in bed with eyes closed with no signs or symptoms of pain. 04/14/26 at 04:03 PM, Administrative Nurse F verified R5's Care Plan lacked information regarding hospice visits, phone numbers, and medical supplies that hospice services would provide. Administrative Nurse F stated the information should be on the resident's care plan. The facility's Hospice Services Policy, revised 01/22/26, documented an interdisciplinary care plan would be established, which integrates the care and services provided by the facility and the hospice provider, including : 1. Resident, staff, and physician comfort with dealing with death 2. Family expectations, 3. Resident and family knowledge of disease progression and eventual outcome 4. Staff time required to provide necessary care and services 5. Cultural and ethnic diversity 6. Communication and/or coordination of participants and agencies providing aspects of palliative care.

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F 0880 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide and implement an infection prevention and control program. Based on observation, record review, and interview, the facility failed to implement acceptable infection control practices related to hand hygiene when staff failed to change gloves or wash hands between cares for Resident (R)6. Findings included: - On 04/15/26 at 10:21 AM, observation revealed R6 rested in bed with her eyes closed. Licensed Nurse (LN) H and Certified Nurse Aide (CNA) M donned gowns applied an N95 mask and gloves, then entered the resident's room and explained to R6 they were going to look at the wound on her bottom and provide catheter care. CNA M and LN H uncovered R6 to reveal the resident had no incontinent brief on. LN H assisted R6 in turning on her left side. CNA M separated the middle of R6's buttocks to reveal an open area approximately 0.3 centimeters (cm) long by 0.2 CM wide. CNA M provided catheter care on the tubing, starting from the insertion site down the tubing with a wet soapy washcloth, then used a dry one on the tubing. Further observation revealed LN H positioned R6 on her back, then separated R6's labia, then, with the same soiled gloves, pulled down the resident's front blouse, and placed her hands on the cloth bed pad to assist CNA M in pulling R6 up in bed. Further observation revealed that, with the same soiled gloves, LN H pulled the resident sheet and blanket over R6, placed the bed control in her right hand, and used the control to put R6's head of bed up, then removed and discarded the gloves, gown, and mask in a trash can. LN H verified she had not changed gloves after assessing R6's labia and stated she should have.On 04/15/26 at 12:08 PM, Administrative Nurse E stated she would expect staff to change gloves and wash hands when providing care, when going from dirty to clean.The facility's Infection Control Policy, revised 01/19/26, instructed staff to remove soiled gloves, wash hands, and change gloves after having contact with infectious material and before leaving the resident's environment, and wash hands immediately with antimicrobial soap.