

Department of Health & Human Services
Centers for Medicare & Medicaid Services

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No. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 175502	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 07/22/2026
NAME OF PROVIDER OR SUPPLIER Medicalodges Eudora		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 Maple Street Eudora, KS 66025	
For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.			
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F 0689 Level of Harm - 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** Based on observations, record review, and interviews, the facility failed to ensure an environment free from accident hazards when Certified Nurse Aide (CNA) O did not use a gait belt during a transfer for Resident (R) 2 resulting in a fall where R2 sustained a fracture. The facility further failed to ensure interventions to prevent falls were implemented for R14 and failed to ensure staff used a full body lift safely for R9. Findings included:- R2 admitted to the facility on [DATE], discharged to the hospital on [DATE], and readmitted to the facility on [DATE]. R2's Electronic Medical Record (EMR) documented diagnoses of a need for assistance with personal care and lack of coordination. R2's Annual Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 13, which indicated intact cognition. The MDS documented R2 had impairment of both upper extremity and lower extremity on one side. The MDS noted R2 could walk 10 feet. She required set-up and clean-up assistance with bathing, including tub/shower transfers. R2's Falls Care Area Assessment (CAA) dated 12/23/2025 documented R2 had non-injury falls in the past 6 months. The CAA noted R2 did not always make safe choices with her abilities and with alerting staff of needs. Her medications also increased her fall risk. R2 scored mod/high risk on assessment and interventions were reviewed and ongoing with updates as needed. R2's Quarterly MDS dated 05/28/2026 documented a BIMS of 8, which indicated moderately impaired cognition. The MDS noted she had impairment on both sides of her upper and lower extremities, required partial/moderate assistance with showering, and did not walk. The MDS noted tub/shower transfers were not attempted due to medical condition or safety concerns. R2's Care Plan dated 12/27/2024 documented she needed assistance with activities of daily living (ADL) related to physical limitations. R2 needed assistance from one staff member for dressing and personal care. The plan noted she was at risk for falls and had limitations on the right side of her body. R2's Care Plan dated 01/10/2025 documented she needed assistance with hygiene and peri care. R2's Fall Risk Assessment v1.0 dated 10/22/2025 documented R2 was at moderate risk for falls and (continued on next page)		

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 0689 Level of Harm - Actual harm Residents Affected - Few	noted she had 1 to 2 falls in the previous six months. The assessment noted R2 required hands-on assistance to move from place to place. A Nurse's Note on 02/20/2026 documented that Licensed Nurse (LN) I was alerted that R2 fell in the shower on the back hall and appeared injured. LN I and LN H went to the shower room and saw R2 on the floor with her back to the shower, and her legs pointed towards the door, in a seated position. CNA O informed LN I that she was transferring R2 from the shower chair to the wheelchair and R2's feet slid out from under her. R2 was in too much pain to do a physical exam, but LN I could visibly see that the left leg was about three inches shorter than the right leg while in the seated position on the floor. The note documented that R2 was bare footed on a wet floor, and no gait belt was being used at the time of transfer. LN H's Statement on 02/21/2026 documented LN H was finishing up charting at the front desk when Dietary Staff BB informed LN I that R2 fell and appeared to be injured as R2 was yelling. LN H and LN I went to the 300-hall shower room and found R2 on the floor directly in front of the shower, with her back towards the shower and her feet directly out in front of her, facing the doorway. R2 was in too much pain to get a good look at her left leg. R2 was crying and stated her left leg hurt from her knee to her groin. R2 could not lie flat, so staff assisted her with a gait belt and not bearing weight on her left leg to the wheelchair. The staff called the physician but were unable to get a hold of an on-call provider. Staff called 911, and LN H stayed with R2 until their arrival. CNA O's Statement on 02/21/2026 documented CNA O was giving R2 a shower about 07:00 PM. CNA O had washed R2, washed her hair, and dried R2 off to dress her. R2 stood up out of the shower chair and turned to sit in her wheelchair. CNA O grabbed the towel, and R2 lost her balance and fell backward. CNA O went to get the nurse before getting her up. Dietary Staff BB's Statement on 02/21/2026 documented she heard screaming and crying around 07:30 PM and CNA O came out of the shower room calling for help. Dietary Staff BB entered the shower room and noticed R2 on the floor on her back, with her feet towards the door, crying out. CNA O informed Dietary Staff BB that she was helping transfer R2 from the shower chair to a wheelchair when R2 fell. R2 did not have a gait belt on, and her feet were bare. Dietary Staff BB informed CNA O not to move R2 and alerted LN I and LN H of the incident. A Nurse's Note dated 02/23/2026 documented R2 returned to the facility from the local hospital at 03:29 PM. The note documented R2 had undergone a Gamma nailing (minimally invasive surgical procedure to stabilize severe hip or thigh fractures) and had a surgical incision with staples on her left hip. Observation on 07/21/2026 at 07:58 AM revealed R2 sat in her recliner watching television with her call light within her reach. R2 stated she had already had breakfast. Observation on 07/21/2026 at 02:11 PM revealed R2 slept in her recliner with her walker across the room, and her wheelchair next to her recliner. R2 wore shoes, which were tied. On 07/22/2026, CNA O was unavailable for interview and did not return the call as requested. (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	that resulted in a left hip fracture repair, and she required a non-removable support for her lower left arm. R14 had an intervention dated 06/04/2026 that instructed staff to ensure orthopedic (pertaining to bones) precautions, pertaining to alignment of joints when resting or in her wheelchair, were utilized. Staff was also instructed to provide R14 with constant reminders not to cross her legs. An intervention dated 06/05/2026 directed that she was to have a knee spacer between her knees to support hip alignment when she was in her wheelchair, and when in bed, and another spacer between her lower calf area. An intervention dated 07/13/2026 documented that R14 had a non-injury event on 07/05/2026 and had assist bars placed on her bed, a fall mat on the floor, and an overlay (mattress topper that uses built-in foam bolsters to create raised edges) to define the edges of her bed. Observed on 07/20/2026 at 08:29 AM, R14 was lying on her right side in bed covered with blankets. Her bed was in a low position near the floor. She appeared to be sleeping. Her bed was in the low position, and there was a fall mat on the floor on each side of the bed, but there was no overlay with bolsters on her mattress. Observed on 07/21/2026 at 07:45 AM, R14 resting in bed with her eyes closed. Her bed was in a low position, and there was a fall mat on the floor on each side of the bed, but there was no overlay with bolsters on her mattress. Observed on 07/21/2026 at 12:28 PM, R14 sitting sat up in bed eating a snack with her legs crossed. There was no spacer between her knees or lower calves. On 07/21/2026 at 01:15 PM, Certified Nurse Aide (CNA) M said a mattress overlay with bolsters was not on R14's bed, and she had been unaware that R14 was to have that. She also said that R14 should have had a spacer pillow between her legs. On 07/21/2026 at 01:30 PM, Licensed Nurse (LN) G confirmed R14 was to have an overlay with bolsters on her mattress but did not have one. She also said that R14 should have had a spacer between her knees and not crossing her legs. On 07/21/2026 at 02:00 PM, Administrative Nurse D said the mattress they had did not fit R14's mattress, but she was supposed to have one. She also said that she expected the spacer pillows were to be used but said R14 would remove them. Administrative Nurse D stated she expected staff to get her up or put them back in place when that happened. 3. R9's EMR documented diagnoses that included ischemic stroke, cerebral edema (swelling of the brain), lack of coordination, and muscle weakness. R9's Annual MDS, dated 07/12/2026, documented a BIMS score of 15, which indicated intact cognition. The MDS documented R9 had impairment in one side upper and lower extremities and used a wheelchair for mobility. R9 was dependent on staff for transfers, lower body dressing, and toileting hygiene. He required partial to moderate assistance for eating and oral hygiene, and required substantial to maximum assistance for upper body dressing. The MDS documented that R9 had two or (continued on next page)		

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F 0689 Level of Harm - Actual harm Residents Affected - Few	more falls since he was admitted . Observed on 07/21/2026 at 09:45 AM, CNA M and CNA N transferred R9 from his bed to his wheel by Hoyer (total body mechanical lift) lift. CNA M operated the lift and raised R9 from the bed, and CNA N maintained contact with him while he was lifted from the bed. While R9 was suspended in the air over his bed, CNA N took her hands off the resident and moved his wheelchair while CNA M began moving and propelling the lift, while R9 was suspended in the air, towards the wheelchair. CNA N then put her hands back on R9 and guided him. CNA M then removed her hands from the lift, adjusted R9's wheelchair, and lowered him into it while CNA N guided him. On 07/21/2026 at 09:57 AM, CNA M said that two staff were required anytime a resident was transferred with the Hoyer lift. She said that one staff member operated the lift and the second staff member would hold onto the lift sheet and guide the resident. CNA M said that she was unsure if staff were to maintain constant contact with the resident or lift during a transfer. On 07/21/2026 at 01:30 PM, LN G said there would always be two staff members when a resident was transferred with the Hoyer lift; one staff member controlled and operated the lift and was never to take their hands off the lift, and the second guided the resident and was to never take their hands off the resident until the resident had been lowered safely. On 07/21/2026 at 02:00 PM, Administrative Nurse D said there were always two staff members when the Hoyer lift was used; one staff member operated the lift, and the second guided the resident during the transfer. She also said neither staff were to remove their hands ever when transferring a resident with the lift. The facility policy Falls management, dated 12/2022, documented that the plan of care was to address individualized resident focus, goals, and interventions directed towards reducing the resident's risk of injury and potential reoccurrence of falls.		

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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 interview, and record review, the facility failed to provide the services of a full-time certified dietary manager for the 41 residents who resided in the facility and received their meals from the kitchen. Findings included:- Record review lacked documentation that Dietary staff BB had her certification as a dietary manager. During an interview on 07/20/2026 at 07:45 AM, Dietary staff BB stated that she was the dietary manager and was not certified yet but was taking classes. Dietary staff BB took over the position in March of 2026 as the last dietary person had walked out. Dietary staff BB stated that she had been an employee at the facility for eight or nine years as a CNA and a CMA, so she was familiar with the residents. During an interview on 07/21/2026 at 09:55 AM, Dietary staff BB stated that she had trained some of the staff in the basics of the kitchen but would ask a nurse or someone with knowledge to answer her questions on food allergies if needed and would research the subject. The facility did not provide a policy upon request.		

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F 0865 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Have a plan that describes the process for conducting QAPI and QAA activities. Based on observations, record reviews, and interviews, the facility failed to maintain an effective quality assessment and assurance (QAA) program to address quality deficiencies prior to survey. Findings Included: - The facility failed to obtain informed consent from the residents or the residents' legal representatives for the installation of bedrails for Resident (R) 10, R14, R1, and R39. (Refer to F700)The facility failed to properly train staff on the proper use of the Hoyer (total body mechanical lift) lift for safe transfer of residents. R9 was transferred by Hoyer lift, and both staff members removed their hands from the lift and R9 while he was suspended in the air and transferred. (Refer to F689)The facility failed to ensure interventions were being utilized to prevent resident injury and falls. R14 did not have an overlay (mattress topper that uses built-in foam bolsters to create raised edges) on her bed to define the edges as directed by her plan of care. (Refer to F689)Observed on 07/21/2026 at 09:45 AM, Certified Nurse Aide (CNA) M and CNA N transferred R9 from his bed to his wheel by Hoyer (total body mechanical lift) lift. CNA M operated the lift and raised R9 from the bed, and CNA N maintained contact with him while he was lifted from the bed. While R9 was suspended in the air over his bed, CNA N took her hands off the resident and moved his wheelchair while CNA M began moving and propelling the lift, while R9 was suspended in the air, towards the wheelchair. CNA N then put her hands back on R9 and guided him. CNA M then removed her hands from the lift, adjusted R9's wheelchair, and lowered him into it while CNA N guided him.On 0720/2026 at 07:47 AM, Administrative Staff A said that the facility's Quality Assurance Performance Improvement Team (QAPI) team officially meets every quarter at a minimum but usually meets monthly. She said current improvement plans being monitored and tracked included urinary tract infection (UTI) and antibiotic stewardship, staff engagement communication breakout sessions, providing room-to-room activities, handwashing, providing residents with snacks and hydration, and CNA documentation. She said the next QAPI meeting was to be scheduled for 07/28/2026 and they were to discuss and implement an improvement plan for accident and fall prevention.The facility policy Quality Assurance Improvement Plan, dated 01/2025, documented that the facility had a performance improvement program which systematically monitored, analyzed, and improved its performance to improve resident outcomes.		

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F 0700 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	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. Based on interview, observation, and record review, the facility failed to obtain informed consent from the residents or the resident's legal representative for installation of bedrails for Resident (R) 10, R14, R1 and R39. Findings include:1. The Electronic Health Records (EHR) for R10 included diagnoses of 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), hemiplegia and hemiparesis following cerebral infarction affecting right non-dominant side (severe functional limitations, including balance issues, reduced mobility, and possible communication difficulties, requiring a multidisciplinary rehabilitation approach), blindness in right eye, muscle weakness, and acquired absence of right leg below kneeThe Restraint Use Assessment-V3, dated 01/09/2026, documented R10 had quarter bed rails to enhance bed mobility, and they were not considered a restraint.R10's EHR lacked evidence of informed consent for bed rails.Observed on 07/20/26 at 09:15 AM, R10 had upper side rails on each side of her bed.2. The EHR for R14 included diagnosis of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), age-related osteoporosis (abnormal loss of bone density and deterioration of bone tissue with an increased fracture risk) with fracture of femur (thigh bone), fracture of lower end of left humerus (upper arm bone), reduced mobility, muscle weakness, and difficulty walking.R14's EHR lacked evidence of a bed rail assessment and informed consent for bed rails.Observed on 07/20/2026 at 08:29 AM, R14 had upper side rails on each side of her bed.3. The EHR for R1 included diagnoses of adult failure to thrive and depression.The Restraint Use Assessment-V3, dated 09/08/2025, documented R1 had quarter rails to enhance his independence with bed mobility and transfers.The Restraint Use Assessment-V3, dated 01/03/2026, documented R1 had quarter rails to enhance his independence with bed mobility and transfers.R14's EHR lacked evidence of informed consent for bed rails.Observed on 07/20/2026 at 09:25 AM, R1 had upper side rails on each side of her bed.4. The EHR for R39 included a diagnosis of adult failure to thrive, depression, and disorientation.The Siderail Assessment V1.0, dated 12/16/2025, documented R39 was not ambulatory with or without assistance, she had impaired memory, cognition, or decision-making, and she had diagnoses or conditions, or received medication that required increased safety measures.R39's EHR lacked evidence of informed consent for bed rails.Observed on 07/20/2026 at 09:56 AM, R39 had upper side rails on each side of her bed.On 07/21/2026 at 01:15 PM, Certified Nurse Aide (CNA) M said approval from therapy had to be obtained before bedrails were used and maintenance attached them. She was unsure if consent was required, but it had to be documented if they were utilized.On 07/21/2026 at 01:30 PM, Licensed Nurse (LN) G said that informed consent along with an assessment were required before bedrails were utilized. She then stated that they had not used bedrails and that the facility had used hand assist rails.On 07/21/2026 at 02:00 PM, Administrative Nurse D said bedrails were not used; assist bars had been utilized. She then stated that informed consent was required before bedrails were used, along with an assessment.The facility policy Side Rail Use and Assessment documented that the purpose of the policy was to ensure the automatic use of side rails of any size or shape was avoided. The policy also documented that the use of side rails was based on residents' assessed medical/psychological needs: it is documented clearly, including risks, benefits, and other alternatives, and periodically reviewed.		

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F 0558 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Reasonably accommodate the needs and preferences of each resident. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, record review, and interview, the facility failed to ensure Resident (R)4's call light was within her reach to enable her to call for staff assistance. Findings included:- R4's Electronic Medical Record (EMR) from the Diagnosis tab documented diagnoses of Alzheimer's disease (progressive mental deterioration characterized by confusion and memory failure), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), dementia (a progressive mental disorder characterized by failing memory and confusion) and repeated falls. R4's Quarterly Minimum Data Set (MDS) dated [DATE] documented a Brief Interview for Mental Status (BIMS) score of 11, indicating moderately impaired cognition. She required substantial to maximum assistance with most activities of daily living (ADL). She had no functional impairment of her upper extremities. R4's Care Plan dated 02/25/2026 documented that R4 will have her call light within her reach and staff will encourage her to use it and ask for assistance. Observation on 07/20/2026 at 07:55 AM revealed R4 in bed asleep. R4's call light was on the nightstand and not within her reach. Observation on 07/21/2026 at 08:07 AM revealed R4 laying in bed awake with blankets on, staring at the window with the blinds closed. There were two call lights draped over the nightstand not within R4's reach. R4's wheelchair was across the room. Her bedside table was over the bed with a cup sitting on it. During an interview on 07/22/2026 at 10:28 AM, Certified Medication Aide (CMA) S stated that the call light needs to be in R4's reach. CMA R says R4 rarely uses the call light, but she will use it if she is fully awake. During an interview on 07/22/2026 at 10:32 AM, Licensed Nurse (LN) G stated that R4 should have her call light within her reach as R4 does use her call light. During an interview on 07/22/2026 at 12:25 PM, Administrative Nurse D stated that all residents should always have their call light in reach. Policy for Providing Quality Care and Accommodation of Needs requested but not received.		

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F 0658 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure services provided by the nursing facility meet professional standards of quality. Based on interview, observation, and record review, the facility failed to provide services to meet professional standards of care when staff failed to ensure Resident (R)5's Electronic Medical Record (EMR) contained appropriate documentation for a schizoaffective disorder (a mental disorder characterized by gross distortion of reality, disturbances of language and communication, and fragmentation of thought) diagnosis. Findings included:- R5's EMR revealed diagnoses of anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear), major depressive disorder (major mood disorder that causes persistent feelings of sadness), schizoaffective disorder, bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods), bipolar disorder (a major mental illness that causes people to have episodes of severe high and low moods). R5's 01/19/2026 admission Minimum Data Set (MDS) documented a Brief Interview of Mental Status (BIMS) score of ten, which indicated moderately impaired cognition. R5's MDS did not show a diagnosis of schizophrenia. The Functional Abilities Care Assessment (CAA) dated 01/19/2026 documented R5 was cognitively impaired and required assistance with activities of daily living and with cueing and prompting. R5's Quarterly MDS, dated 03/05/2026, documented a medical disorder of schizophrenia. The Medication Administration Record (MAR) dated January 2026 documented Seroquel/quetiapine (antipsychotic) given for mood. The MAR dated February, March, April, June & July 2026 documented Seroquel/quetiapine was given for schizoaffective disorder. A U.S. Department of Veterans Affairs (VA) medical history report dated 10/28/2025 did not document a diagnosis of schizoaffective disorder. R5's 01/15/2026 Antipsychotic Medication Informed Consent lacked schizoaffective disorder as a reason for the use of medications. On 02/05/2026, the physician signed a Medication Review Report, dated 02/02/2026 through 02/28/2026, which showed the antipsychotic medication Seroquel/quetiapine was ordered but did not document schizoaffective disorder as a diagnosis in the diagnosis summary. On 03/05/2026, the physician signed a Medication Review Report, dated 03/04/2026 through 03/31/2026, which documented the antipsychotic medication Seroquel/quetiapine fumarate was ordered and documented schizoaffective disorder as a diagnosis in the diagnosis summary. R5's 01/18/2026 Care Plan lacked documentation regarding schizoaffective disorder. R5's 02/20/2026 Nursing Progress Note documented that the resident was okay and slept through the night as usual. R5's 02/27/2026 Pharmacy Note to Attending Physician documented a request to the physician to add the diagnosis schizoaffective disorder. R5's EMR lacked physician documentation of specific behaviors, clinical findings, and assessments supporting the addition of the schizoaffective diagnosis. During an observation on 07/20/2026, R5 was lying in bed watching television. During an interview on 07/22/2025 at 08:45 AM, Administrative Nurse D reported that R5 admitted to their facility with a diagnosis of schizophrenia from the VA and further stated the diagnosis may have come from a medical team that comes into the facility and visits patients that are receiving antipsychotic medications. The facility's medication error reporting and adverse drug reaction prevention and detection policy dated 2007, documented that the interdisciplinary team reviews the resident's medication regimen for efficacy and actual or potential medication-related problems on an ongoing basis. The policy further documented that an active diagnosis/indication (and documented objective findings, if necessary) supports the use of the medication		

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NAME OF PROVIDER OR SUPPLIER Medicalodges Eudora		STREET ADDRESS, CITY, STATE, ZIP CODE 1415 Maple Street Eudora, KS 66025	
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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide appropriate treatment and care according to orders, resident's preferences and goals. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interviews and record reviews, the facility failed to ensure appropriate care and services to promote wound healing for Resident (R) 36 when staff failed to use the correct physician's treatment order. Findings included:- R36's Electronic Health Record (EHR) documented diagnoses that included left ankle and foot osteomyelitis (local or generalized infection of the bone and bone marrow), elevated white blood cell count, anemia (an inadequate number of healthy red blood cells to carry adequate oxygen to the body), chronic kidney disease, atrial fibrillation (rapid, irregular heartbeat), bradycardia (low heart rate, less than 60 beats per minute), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin made, or the body cannot respond to the insulin), hypertension (HTN-elevated blood pressure), neuropathy (weakness, numbness, and pain from nerve damage, usually in the hands and feet), absence of three toes on the left foot. R36's 07/16/2026 admission Minimum Data Set (MDS) documented R36 had an infection of the foot and a surgical wound. The MDS further documented R36 was receiving surgical wound care. R36's Care Plan documented she was receiving daily wound dressings to the surgical site to the left foot. The plan further documented R36 was receiving intravenous (IV-administered directly into the bloodstream via a vein) antibiotic treatment. R36's skin condition progress note dated 07/11/2026 documented a surgical incision site with seven staples to the left foot. The surgical incision was from an amputation (surgical removal of a body part) of the third toe. The skin condition progress notes further documented the surgical incision was to be cleansed with normal saline (NS-saline water solution for medical use) and an Aquacel AG (brand name of a specific type of wound dressing) applied over the surgical incision. R36's physician's order dated 07/10/2026 documented nursing staff was to cleanse the wound with NS and then apply Aquacel AG to R36's left third toe site over the surgical staples. Staff was then to apply gauze or an ABD pad (large pad to absorb drainage) to the surgical site. Observation on 07/21/2026 at 08:43 AM showed R36 lying on his bed with Licensed Nurse G at bedside. Licensed Nurse (LN) G performed the dressing change and applied [NAME] Collagen (Brand name of a specific type of dressing) to the wound instead of the ordered Aquacel AG. On 07/21/2026 at 08:46 AM, R36 stated there was no pain in the surgical site; the infection in the surgical site was the problem. On 07/22/2026 at 11:09 AM, LN G stated the nurse should follow the physician's treatment order and stated the Aquacel AG was not available, so the [NAME] Collagen was substituted. On 07/22/2026 at 01:23 PM, Administrative Nurse D stated she expected staff to follow the physician orders for wound treatments. Administrative Nurse D said LN G should have called the physician to obtain an order for a different treatment when the ordered treatment was not available. The facility prevention and wound management policy documented that the facility will provide a systematic approach for identifying residents at risk for skin breakdown and develop interventions to decrease the incidence of residents who develop pressure ulcers while providing guidelines for optimal care to promote healing for residents with all identified skin alterations.		

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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe and appropriate respiratory care for a resident when needed. Based on observation, interview, and record review, the facility failed to ensure adequate services for respiratory care when staff failed to provide Resident (R) 44 with as needed (PRN) breathing treatments as ordered for shortness of air (SOA)/shortness of breath (SOB). Findings included:- The Electronic Health Records (EHR) for R44 included diagnoses of acute and chronic respiratory failure with hypoxia (inadequate supply of oxygen), chronic combined systolic (congestive) and diastolic (congestive) heart failure, chronic obstructive pulmonary disease (COPD- a progressive and irreversible condition characterized by diminished lung capacity and difficulty or discomfort in breathing), and obstructive sleep apnea.R44's admission Minimum Data Set (MDS), dated for 01/22/2026, documented a Brief Interview for Mental Status (BIMS) of 15, which indicated cognitively intact. The MDS documented that R44 required setup or cleanup assistance for eating, partial to moderate assistance for oral hygiene, refused the bathing assessment, and required substantial to maximum assistance for all other activities of daily living (ADL). The MDS documented that she had SOB or trouble breathing when she laid flat and that she used a non-invasive mechanical ventilator.R44's Quarterly MDS, dated 06/25/2026, documented a BIMS of 13. The MDS documented that she had COPD and respiratory failure.R44's Care Plan, dated 02/03/2026, documented she took medication to manage chronic and acute pain in her back and feet. Staff were instructed to monitor for signs of overdose that included breathing difficulties and respiratory arrest (completely stopped breathing).R44's Care Plan, dated 02/09/2026, documented she was on a recommended fluid limitation for her health. Staff was instructed to observe any changes in blood pressure, urine output, skin turgor, cognitive status, and activity tolerance.R44's Care Plan did not have documentation related to her COPD or her PRN breathing treatments.R44's EHR documented a Physician's Order, dated 01/14/2026, for ipratropium-albuterol inhalation solution (a combination bronchodilator used to prevent and treat airway narrowing in COPD patients) 0.5-2.5 milligrams (MG)/three milliliters (ML), one vial inhaled orally every six hours as needed for SOB.The 06/24/2026 at 04:10 PM Wellness Meeting Note documented R44 did not participate in any activities that shift, as she normally did, and did not have much of an appetite. R44 had complaints of pain in her low back and felt short of air and requested to speak with the provider.The 06/24/2026 at 08:18 PM Orders Note documented that R44 had been seen by the provider, and a two-view chest x-ray had been ordered for SOA.The 06/27/2026 at 11:12 AM Transfer Note documented that when the nurse went into R44's room, she was leaning over and soaked with sweat and urine. The note documented that she could not tell the nurse where her pain was and had a temperature of 103.0 degrees Fahrenheit. The provider was notified, and R44 was sent to the hospital for further evaluation.R44's June 2026 Medication Administration Record (MAR) documented that the only PRN breathing treatment was administered on 06/13/2026. There were no documented refusals.Observed on 07/21/2026 at 12:38 PM, R1 was lying in bed awake. Upon opening the door, a strong urine smell wafted out of the room.On 07/21/2026 at 01:15 PM, Certified Nurse Aide (CNA) M said she would have known if a resident was SOA/SOB if their breathing was not normal for them, or they had audible wheezing. She would then notify the nurse.On 07/21/2026 at 01:30 PM, Licensed Nurse (LN) G said if the CNA reported a resident had difficulty breathing or wheezing, she would have attempted to give them a breathing treatment, especially if there was a standing order. She also said she would have attempted to give them a breathing treatment if they had SOA/SOB; if they refused, she would have documented it and notified the provider.On 07/21/2026 at 02:00 PM, Administrative Nurse D said that if a resident had SOA/SOB and they had orders for PRN breathing treatments, she expected the nurse to have at least attempted to give them the treatment. (continued on next page)		

Department of Health & Human Services
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F 0695 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	She said if they refused, she expected them to document the refusal and notify the provider. The facility policy Clinical Resources for Implementing Standards of Care, dated 11/2024, documented that clinical resources would be used as guidelines for implementation of standard of care practices for the delivery of services to residents.		

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F 0760 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure that residents are free from significant medication errors. Based on observation, record review and interviews, the facility failed to ensure Resident (R)33 remained free from a significant medication error when staff failed to follow the physician prescribed administration schedule for R33's Carbidopa-Levodopa (medication used to control tremors shaking associated with Parkinson's disease). Findings included:-R33's Electronic Medical Record (EMR) documented R33 had diagnoses of major depressive disorder (major mood disorder that causes persistent feelings of sadness), Parkinson's disease (a slowly progressive neurologic disorder characterized by resting tremors, rolling of the fingers, masklike faces, shuffling gait, muscle rigidity, and weakness), anxiety (mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear). The admission Minimum Data Set (MDS), dated 04/09/2026, documented R33 had a Brief Interview for Mental Status (BIMS) score of 15, which indicated intact cognition. The MDS documented R33 required staff assistance for toileting, bathing, dressing, and transfer. The Functional Abilities Care Area Assessment (CAA), dated 04/20/2026, documented R33 required staff assistance with activities of daily living (ADLs) due to weakness. The Medication Administration Record (MAR), dated July 2026, documented carbidopa-levodopa 25 milligrams-100 milligrams by mouth four times daily was started on 04/02/2026. The 04/02/2026 order details report documented the facility time code for administration of the carbidopa-levodopa four times a day at 06:00 AM; 10:00 AM; 02:00 PM, and 08:00 PM daily. The hospital discharge physician orders dated 07/07/2026, when R33 returned to the facility, showed the order for carbidopa-levodopa to be administered four times daily at 07:00 AM; 11:00 AM; 03:00 PM and 07:00 PM. On 07/21/2026 at 12:28 PM, observation revealed R33 sitting in a recliner and stated she had just finished her lunch and was waiting for her afternoon medications. On 07/20/2026 at 03:53 PM, R33 stated she was very distressed with the facility for not following the doctor's orders for the times she was supposed to receive her carbidopa-levodopa every day. She stated the physician had emphasized the importance of the administration times. R33 stated she had discussed this issue with the facility staff, but nothing changed. R33 stated that sometimes staff woke her at 05:00AM to administer the morning dose. On 07/21/2026 at 04:08 PM, Certified Medication Aide (CMA) R reported she administered the 03:00 PM Carbidopa-Levodopa at 01:38 PM. On 07/22/2026 at 12:35 PM, CMA R stated the MAR tells staff what time to administer the carbidopa-levodopa and verified the MAR showed the medication was due daily at 07:00 AM, 11:00 AM, 03:00 PM, and 08:00 PM. The night nurse administers the 07:00 AM dose before they leave work at 06:00 AM each day. On 07/22/2026 at 12:49 PM, Licensed Nurse (LN) H reported the night shift nurse administers the morning dose of R33's carbidopa-levodopa prior to the end of their shift at 06:00 AM each day, and the CMA administers the remaining doses each day. On 07/22/2026 at 12:40 PM, Administrative Nurse D reports the physician's order for the carbidopa-levodopa medication administration should follow the physician's order and the facility's medication administration policy. The medication error reporting and adverse drug reaction prevention and detection policy dated 2007 showed the facility utilizes a system to assure that medication usage is evaluated on an ongoing basis.		

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F 0732 Level of Harm - Potential for minimal harm Residents Affected - Many	Post nurse staffing information every day. Based on observation, interview, and record review, the facility failed to ensure the posted nurse staffing contained the required information when staff failed to include the resident census or posted an inaccurate census. Findings included:- Observation on 07/20/2026 at 07:38 AM revealed the Daily Staff Posting posted nurse staffing sheets for 07/19/2026 and 07/20/2026. The sheets did not have the census or the actual hours worked posted on the form. Review of the Daily Staff Posting sheets revealed the sheet had a line for the facility name and date, but not for the census. The sheet had the nurse staff breakdown by shifts (First, Second, and Third) and further by eight-hour shift and/or twelve-hour shifts. Review of the July 2026 staffing sheets revealed each sheet lacked the required information, including census and the actual hours worked for each Registered Nurse (RN), Licensed Practical Nurse (LPN), and Certified Nurse Aide (CNA/Certified Medication Aide (CMA). On 07/22/2026 at 01:17 PM, Administrative Nurse D stated the daily posting form should be filled out completely and accurately. On 07/22/2026 at 01:18 PM, Administrative Staff A stated all the required areas for the daily staffing should be completed each day. The facility's Benefit Improvements Protection Act (BIPA) Nurse Staff Posting policy, revised 12/2019, indicated the facility will post staffing data each shift for the direct care and licensed nurses. The policy indicated the daily posted staffing will identify the census at the beginning of each shift to track the necessary staffing required.		