STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andbe Home, Inc	201 W Crane Street Norton, KS 67654

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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 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, interview, and record review, the facility failed to store, prepare, and serve food in a sanitary manner for the residents who reside in the facility and receive meals from the facility kitchen. Findings included:- On 05/05/26 at 08:18 AM, during the initial tour of the facility's kitchen, observation revealed the following;1. Dietary Staff (DS) BB prepared and served breakfast without a hairnet.2. The double-door stainless refrigerator had the following:A quart-size heavy whipping cream with an expiration date of 01/04/26.Deli-style sliced ham in a gallon-size bag with no open date and not sealed.A yellow-square sliced cheese stored in a gallon bag without an open date or expiration date.Three sausage patties and links were stored in a sandwich-sized bag without a label of contents or an open date.White round sliced cheese stored in a gallon-size bag without a label of contents or an open date.Shredded white and yellow shredded opened and taped shut without an open date.Swiss cheese slices were stored in a gallon-size bag without an open date.Oven-roasted deli-style turkey slices stored in a gallon-size bag without an open date.3. The fryer oil was dark and had debris floating on the surface.4. The floor of the walk-in freezer had a hash brown patty and a potato cube sitting on the floor.5. The walk-in refrigerator had three boxes, each containing four gallons of ice cream liquid/mix, stored directly on the floor, and a bag of lettuce, which had brown, slime-like contents.6. The metal shelving sitting outside the walk-in refrigerated, which stored fruit juices, was rusted throughout the surface of the shelves.7. The dry storage had cardboard boxes of potato chips sitting directly on the floor and a #10 can of Sloppy [NAME] sauce that was dented.8. The dry storage room shelving had vanilla icing labeled with the open date of 10/29/26.9. The floor baseboards and equipment throughout the kitchen had dark, blackish, greasy material surrounding the edges. On 05/05/26 at 08:30 AM, DS BB verified that food should be stored in a closed container and labeled with open dates. DS BB disposed of unlabeled items. On 05/06/26 at 11:33 AM, DS CC wore a hairnet that covered the top half of her head, with hair exposed on the lower half of her head. DS CC verified staff should have hairnets on while in the kitchen. Upon walking through the kitchen, the fryer continued with dark colored oil and debris floating on the top. The fryer baskets had crusty material attached. The plastic container on the shelf near the hot steam location, where clean cooking utensils were stored, was unclean and had food debris inside. In dry storage, a bottle of strawberry syrup had an open date of 07/05/25. The three steam table lids were unclean on the top surface. DS CC reported the cleaning schedule delegated to the kitchen staff should be followed and completed to maintain a clean sanitary kitchen. On 05/07/26 at 01:30 PM, Administrative Staff A verified the kitchen cleaning schedule should be followed. The facility's Food Storage policy dated 2019, documented that all foods should be off the floor, and all foods will be checked to ensure that foods will be consumed by their safe use-by dates. All foods shall be covered, labeled, and dated. The facility's Employee Sanitary Practices policy, dated 2019, documented employees will wear a restraint and clean and sanitize equipment and work areas after use. The facility's General Sanitation of the Kitchen policy, dated 2019, documented food and nutrition service staff will maintain the sanitation of the kitchen through compliance with a written, comprehensive cleaning schedule.

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 0867 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Many	Set up an ongoing quality assessment and assurance group to review quality deficiencies and develop corrective plans of action. Based on observation, record review, and interviews. The facility failed to ensure their Quality Assessment and Assurance (QAA) Committee adequately identified deficient areas of practice to develop and implement appropriate plans of action to correct the deficient practices. Findings included: - The facility failed to provide the Medicare/Medicaid Coverage Liability Notice from 10055, and the form 10123 to the resident and//or representative regarding non-coverage of skilled services. Refer to F582. The facility failed to ensure a stop date for Resident (R)5 who had as-needed antianxiety medication without a 14 day stop date or a definitive stop date. Refer to F605. The facility failed to provide R23 or representatives with a bed hold notification when he was admitted to the hospital. Refer to F628. The facility failed to report R4's change of condition following an unresponsive episode and failed to follow up on charting after the incident. Refer to 684. The facility failed to assist R7, R14, and R31 in determining the root causes of the falls, failed to implement effective interventions, and lacked adequate investigation of the falls to prevent further falls and accidents. Refer to F689. The facility failed to provide nutritional care or notify the physician of R6's weight loss. Refer to F692. The facility failed to provide pre and post dialysis assessments for R41 , who received dialysis treatment, failed to have a contract with the dialysis center and failed to have a care plan for staff to follow for R41 who received dialysis. Refer to F698. The facility failed to wear hairnets, clean the kitchen, and discard unlabeled food. Refer to F812. The facility failed to complete and develop the facility assessment to determine what resources were necessary to provide cares and services completely during both day-to-day operations and emergencies for the 35 residents who reside in the facility, placing the residents at risk for inadequate care. Refer to F838. The facility failed to provide Enhanced Barrier Protection for R8, who had a foley catheter. Refer to F880. On 05/07/26 at 01:30 PM, Administrative Staff A stated the QAA meetings were held monthly and included the medical director. Administrative Staff A verified the deficiencies and confirmed the facility had not self-identified and corrected through performance improvement plans with monitoring done by the QAA committee. The QAPI policy, dated 2026, documented QAPI is the coordinated application of two mutually reinforced aspects of a quality management system: Quality Assurance (QA) and Performance Improvement (PI). QAPI takes a systematic, comprehensive, and data-driven approach to maintaining and improving safety and quality in nursing homes while involving all nursing home caregivers in practical and creative problem solving. The QAPI program would focus on outcomes of the residents' care and quality of life. The performance improvement plan is designed to be ongoing, comprehensive, and address the full range of care and services provided by the facility. The plan is designed to include all clinical care, quality of life, and resident choice.

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F 0582 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Give residents notice of Medicaid/Medicare coverage and potential liability for services not covered. Based on record review and interview, the facility failed to provide Resident (R)42 or their representative the completed Centers for Medicare and Medicaid (CMS) Skilled Nursing Facility Advanced Beneficiary Notices (ABN) form 10055 or the CMS Notice of Medicare Non-Coverage (NOMOC) form 10123, and failed to provide R6 and R7 with the CMS 10055 form. Findings included: - R42's skilled services ended on 12/26/25. R42 remained in the facility. Upon request, the facility was unable to provide evidence R42 received the CMS 10055 form and the CMS Form 10123. R6's skilled services ended on 03/26/26. R6 remained in the facility. Upon request, the facility was unable to provide evidence R6 received the CMS 10055 form. R7's skilled services ended on 02/03/26. R7 remained in the facility. Upon request, the facility was unable to provide evidence that R7 received the CMS 10055 form. On 05/06/26 at 03:50 PM, Administrative Staff A verified the facility did not provide R42 the CMS Form 10123 and the CMS Form 10055, and did not provide R6 and R7 with the CMS Form 10055. The facility did not provide beneficiary notification policy.

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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** Based on observation, interview, and record review, the facility failed to obtain a stop date for three sampled residents, Resident (R) 13, R31, and R5, as needed (PRN) Ativan/lorazepam (a medication that calms and relaxes people). Findings included:- The Electronic Medical Record (EMR) for R13 documented diagnoses of vascular dementia (a progressive mental disorder characterized by failing memory and confusion caused by a decreased blood flow to the brain), violent behavior (the intentional use of physical force or power, either threatened or actual against oneself, another person, or a group), and depression (a mood disorder that causes a persistent feeling of sadness and loss of interest). The admission Minimum Data Set (MDS), dated [DATE], documented R13 had severely impaired cognition. R13 required substantial staff assistance with toileting, bathing, and personal hygiene. R13 had physical and verbal behaviors and rejected care four to six days a week. R13's 04/02/26 Care Plan included the following interventions for R13: 03/20/26- Administer medications as ordered and chart refusals, allow her time in the Special Care Unit (SCU) to wander more freely without the risk of elopement. 03/31/26- Provide consistent staff as much as possible, rule out physiological causes for the behavior. If R13 resists care, stop, and try the task later. Do not force her to do the task unless necessary. Avoid rushing, abrupt changes in care, or environment, to prevent the frustration that results in agitation. Monitor her mood and response to the medication and monitor for drug use effectiveness and adverse effects. The Physician's Order, dated 04/07/26, directed staff to administer Ativan, 0.5 milligrams (mg), three times a day PRN for violent, aggressive behaviors. The order lacked a stop date for the PRN Ativan. On 05/06/26 at 08:00 AM, R13 ambulated up and down the hall in the SCU. Certified Medication Aide (CMA) R stated that R13 had a lot of behaviors and would scream, stating she was going to kill us or that the staff would kill her. As CMA R stated this, R13 walked by and stated, Can you do that to my son? CMA R stated that R13 often paced the hallway, and they tried to keep the other residents' door shut so she would not go in and out of the room. CMA R stated R13 had scheduled and PRN Ativan that they administered to her. On 05/05/26 01:00 PM, Administrative Nurse D stated she could not find any response from the physician regarding the Ativan stop date and would contact the physician. On 05/07/26 at 10:00 AM, Licensed Nurse H stated R13 had a lot of behaviors and would often refuse her medications, but they continued to try to get her to take them. LN H stated she had scheduled Ativan and had a prn Ativan they could administer to her. The facility's Psychotropic Medication Use policy, undated, documents that psychotropic medications are not prescribed or given on a PRN basis unless that medication was necessary to treat a diagnosed, specific condition that was documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. If the prescriber or attending physician believes it was appropriate to extend the prn order beyond the 14 days, he or she would document the rationale for extending the (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	use and include the duration for the prn order. - The Electronic Medical Record (EMR) for R31 documented diagnoses of memory deficit, pain, muscle weakness, and anxiety (a mental or emotional reaction characterized by apprehension, uncertainty, and irrational fear) The Quarterly Minimum Data Set (MDS), dated [DATE], documented R31 had a Brief Interview for Mental Status (BIMS) score of seven, which indicated severely impaired cognition. R31 was independent with transfers and mobility, and transfers. R31 had no behaviors, wandered daily, and received an antianxiety (a class of medication that calms and relaxes people). The Annual MDS dated 03/14/26, documented R31 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severely impaired cognition. R31 was independent with transfers and mobility, and transfers. R31 had inattention and disorganized thinking continuously, delusions, wandered daily, had no behaviors, and received antipsychotic (a class of medications used to treat major mental conditions that cause a break from reality) and antianxiety medications. R31's 03/19/26 Care Plan documented the following interventions: 04/22/25- Attempt non-pharmacological interventions, monitor mood and response to the medication, monitor her behaviors, monitor medication for effectiveness, R31 will reside in the Special Care Unit (SCU) 09/29/25- Administer medications as ordered and monitor adverse reactions. The Physician Orders, dated 04/23/25, directed staff to administer Ativan, 0.25 milligrams (mg), by mouth, three times a day PRN for anxiety. The order lacked a stop date for the PRN Ativan. On 05/05/26 at 12:13 PM, R31 sat in a recliner in the SCU watching television. She was pleasant to the staff and other residents. On 05/05/26 at 03:30 PM, Administrative Nurse D stated the physician had provided a stop date when the pharmacist made the recommendation, but the stop date was never documented in the EMR. On 05/06/26 at 07:45 AM, Certified Medication Aide (CMA) R stated R31 could have behaviors at times, and staff redirected her. CMA R said R31 did not usually have aggressive or violent behaviors, but if needed, she had medication staff could give her. On 05/07/26 at 10:00 AM, Licensed Nurse (LN) H stated R31 had PRN medication that could be given for any behaviors. The facility's Psychotropic Medication Use policy, undated, documents that psychotropic medications are not prescribed or given on a PRN basis unless that medication was necessary to treat a diagnosed, specific condition that was documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days. If the prescriber or attending physician believes it was appropriate to extend the prn order beyond the 14 days, he or she would document the rationale for extending the use and include the duration for the PRN order. - R5's Electronic Health Record (EHR) revealed diagnoses of dementia (progressive mental disorder (continued on next page)

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F 0605 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	characterized by failing memory, confusion), and anxiety (mental or emotional reaction characterized by apprehension, uncertainty, irrational fear). R5 Quarterly Minimum Data Set (MDS) dated [DATE], recorded R5 had moderately impaired cognition. The MDS recorded that she required staff assistance with bed mobility and transfers. The MDS documentation R5 received an antianxiety medication during the observation period. R5's Care Plan, dated 04/10/26, recorded R5 required staff assistance with activities of daily living (ADL) care. R5's Care Plan documented the resident received lorazepam (antianxiety medication) and staff would observe for side effects and effectiveness. R5's Physician's Order, dated 04/08/26, directed the staff to administer lorazepam 0.5 milligrams (mg) PRN. The order lacked a stop date. R5's EMR lacked evidence of a specified duration, which included a physician's rationale for the extended use of the PRN lorazepam. On 05/06/26 at 08:30 AM, R5 sat in a wheelchair at the dining room table. Certified Medication Aide (CMA) R administered the resident's medication. On 05/05/26 at 02:25 PM, Administrative Nurse D verified the resident received lorazepam PRN, with a physician order date of 04/08/26. Administrative Nurse D verified the facility failed to obtain the 14-day stop date or a reason for the continued use with the appropriate rationale. The Psychotropic Medication Use policy dated July 2022 documented residents would only receive antipsychotic medications to treat a specific condition. Considerations of the use of any psychotropic mediation is based on comprehensive review of the residents, that includes evaluation of the residents' signs and symptoms in order to identify underlying causes. Psychotropic medications are not prescribed or given on a PRN basis unless that medication is necessary to treat a diagnosis specific condition that is documented in the clinical record. PRN orders for psychotropic medications are limited to 14 days If the prescriber or attending physician believes it is appropriate to extend the PRN order beyond 14 days; he or she will document that rationale for extending the use to include the duration of the PRN order.

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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** Based on observation, interview, and record review, the facility failed to complete a recapitulation (a concise summary of the resident's stay and course of treatment in the facility) for Resident (R) 38. Findings included:- The Electronic Medical Record (EMR) for R38 documented diagnoses of fracture of the upper end of the left humerus (broken upper arm), displaced fracture of the distal phalanx of the right ring finger (broken finger), and pain. The admission Minimum Data Set (MDS), dated [DATE], documented R38 had intact cognition. R38 required substantial staff assistance with toileting hygiene, showers, and lower-body dressing. R38 required partial staff assistance for upper body dressing, personal hygiene, mobility, and transfers. R38 had upper and lower functional impairment on one side. The Quarterly MDS, dated 01/05/26, documented R38 had intact cognition. R38 required partial staff assistance for upper body dressing, showers, and mobility. R38 required supervision with transfers, toileting hygiene, mobility, and ambulation. R38 had upper and lower functional assessment on one side. R38's 02/27/26 Care Plan documented the following interventions: 10/02/25- Administer medications as ordered and offer non-medicated pain relief measures. 10/06/25- R38 would work with therapy five times a week, and staff will assist with all her care. Encourage her to do as much as possible independently, and when she can't, let staff assist with it. 10/13/25- R38 will rehab at home as soon as she can take care of herself. The Nurse's Note, dated 02/26/26 at 03:42 PM, documented that staff received an order for R38 to be discharged to home in the current condition with an immobilizer (a device or apparatus used to restrict or eliminate the movement of a specific body part in place. The Nurse's Note, dated 02/28/26 at 11:40 AM, documented R38 signed the inventory list and left the facility with her medications R38's EMR lacked a complete recapitulation of her stay in the facility. On 05/06/26 at 11:50 AM, Administrative Nurse D stated the nurses usually did the recapitulation but confirmed she was unable to find one. Upon request, a policy for recapitulation or discharge summary was not provided by the facility. - The Electronic Medical Record (EMR) for R23 documented diagnoses of hydrocephalus (excessive accumulation of fluid within cavities of the brain, the excess fluid puts harmful pressure on the tissues of the brain,) chronic kidney disease (moderate decline in kidney function), diabetes mellitus (DM - when the body cannot use glucose, not enough insulin is made, or the body cannot respond to the insulin), and atherosclerotic heart disease (a buildup of fats, cholesterol, and other substances in an don the artery walls). (continued on next page)

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F 0628 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The admission Minimum Data Set (MDS), dated [DATE], documented R23 had moderately impaired cognition. R23 required staff set up assistance with oral and personal hygiene and atrial to moderate assistance with toileting. R23's Care Plan, dated 02/18/26, directed staff to assist R23 as needed. R23 ambulated with a standard walker in the hallways and was independent with transfers and ambulation. R23's Progress Notes dated 01/30/26 at 10:31 AM, documented R23 was out of the building with a family member for a procedure. R23's Progress Notes dated 02/02/26 at 03:08 PM, documented R23 would have a shunt placed on 02/03/26 and be in the hospital for three days for adjustment as needed. R23's Progress Notes dated 02/18/26 at 09:30 AM, documented R23 returned from the hospital for skilled care. R23 ambulated with a front wheeled walker. R23's clinical record lacked evidence that a copy of the bed hold policy was provided to the resident or representative when he was transferred to the hospital. On 05/06/26 at 07:45 AM, observation revealed R23 ambulated from his room to the dining room with a walker, dressed in street clothes and nicely groomed. On 05/06/26 at 11:50 AM, Administrative Staff A stated they should have had a bed hold notice provided to R23 or the representative before discharge to the hospital, and stated the resident went to a doctor's appointment, then was admitted to the hospital for elevated blood pressure. Administrative Staff A confirmed the facility did not provide the bed hold upon his admission to the hospital. Upon request, the facility lacked a Bed Hold Notification policy.

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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, interview, and record review, the facility failed to apply the standards of practice as related to a change of condition for Resident (R) 4, who had a history of vasovagal response (a reflex of the involuntary nervous system that causes a sudden drop in heart rate and blood pressure, often leading to fainting or lightheadedness) when staff failed to follow the care plan on the use of a full-body mechanical lift and instead used a sit-to-stand lift. R4 lost consciousness and staff failed to contact the physician or family and did not assess R4 after the initial incident. Findings included:- The Electronic Medical Record (EMR) for R4 documented diagnoses of hypotension (low blood pressure, dementia without behavioral disturbances (a progressive mental disorder characterized by failing memory and confusion), diabetes mellitus (DM-when the body cannot use glucose, not enough insulin was made, or the body cannot respond to the insulin) type two, chronic kidney disease (long term condition where kidneys are damaged and gradually lose their ability to filter waste, toxins, and excess fluid from the blood), and hypertension (high blood pressure).The Annual Minimum Data Set (MDS), dated [DATE], documented R4 had intact cognition. R4 was dependent upon staff for transfers, lower body dressing, and toileting hygiene. R4 had no upper or lower functional impairment and did not ambulate.R4's 03/04/26 Care Plan documented the following interventions:05/28/21- Administer medication as ordered and monitor for any adverse reaction.03/09/26- Transfer R4 with two staff and a full lift (total body mechanical lift) until further notice. Physical therapy will work with R4 due to weakness and strengthening. R4's Care Plan lacked documentation to direct staff should R4 have a vasovagal response.The Physician Orders, dated 04/16/26, directed staff to administer metoprolol (a blood pressure medication), 25 milligrams (mg), by mouth, twice a day, for hypertension.The Nurse's Note, dated 04/16/26 at 03:39 PM, documented that the physician came for rounds and was unable to figure out what caused R4's vagal responses, as nothing cardiac showed. R4 took medication for high blood pressure that can cause orthostatic hypotension, so the medication dose would be cut in half. Staff would monitor the resident's blood pressure and pulse and then report to the physician. If her blood pressure remained managed, then the physician would discontinue the medication and readdress using the sit-to-stand lift (a motorized or hydraulic mobility device that helps individuals with limited lower-body strength transition safely from a seated to a standing position), but would only use the full lift until the sit-to-stand lift was deemed safe.The Nurse's Notes, dated 04/25/6 at 12:27 PM, documented that staff called a nurse into R4's room. The resident passed out on the sit-to-stand. She had a large, loose bowel movement; her vital signs were obtained and were normal for baseline. The note stated R4's lungs were clear in all lobes, and the nurse would monitor R4. The nurse asked R4 to squeeze her hands bilaterally, and she was weak on both sides. R4 slowly came around and was able to state her full name. R4 was able to drink a juice supplement independently, but fell asleep every time she was woken up. The Vital Signs report for 04/25/26 documented the following blood pressures:04/25/26 at 12:22 PM- 112/8304/25/26 at 05:55 PM- 108/62The EMR lacked documentation of further follow-up charting regarding the incident.On 05/6/26 at 07:50 AM, Licensed Nurse (LN) G stated staff used to call the physician after R4 passed out, but it had become normal, so they stopped. LN G stated she did not have any documentation that the physician did not want to be called, but she does not call because it happened so frequently. LN G further stated the Certified Nurse Aides (CNAs) took it upon themselves to use the seat to stand when R4 was supposed to have a full lift for transfers, and R4 passed out. LN G stated that there should be follow-up charting after R4 passed out. On 05/06/26 at 11:30 AM, R4 sat in her wheelchair in her room. She stated she preferred surveyors not watch her transfer. On 05/06/26 at 11:45 AM, CNA N stated the CNA staff had been using the full lift for R4's transfers because she had passed out when they used the sit-to-stand lift. On 05/06/26 at 03:45 PM, Administrative Nurse D stated that staff were to use the full lift for transfers; when R4 passed out on the sit-to-stand lift, it was (continued on next page)

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F 0684 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	considered a change in condition, and the nurse was supposed to contact the physician and continue to take R4's blood pressure every 30 minutes. Administrative Nurse D said the nurse should also be monitoring and charting for several days after the event. Administrative Nurse D further stated that there should be documentation in R4's plan of care regarding the vasovagal episodes to provide directions to staff on what they should do when she has an episode.The facility's Change in a Resident's Condition or Status policy, dated 02/21, documented that the facility promptly notified the resident, his or her attending physician, and the resident representative of changes in the resident's medical/mental condition and/or status. The nurse would call the physician if there were a significant change in the resident's physical/emotional/or mental condition, an accident or incident involving the resident, or if there is a need to transfer the resident to a hospital or treatment center. The nurse will record in the resident's medical records relative to changes in the resident's medical/mental condition or status.

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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** Based on observation, interview, and record, the facility failed to accurately investigate a root cause and implement effective interventions to prevent falls for Residents (R) 7 and R31, who had numerous falls. Findings included: - R7's Electronic Medical Record (EMR) documented diagnoses of unspecified dislocation of the hip, 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), depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), congestive heart failure (CHF-a condition with low heart output and the body becomes congested with fluid), and syncope (fainting or passing out) and collapse. R7's Quarterly Minimum Data Set (MDS), dated [DATE], documented that R7 had intact cognition, functional range of motion impairment on one side of the upper and lower extremities, and utilized a wheelchair for mobility. The MDS lacked documentation of R7's functional abilities. The MDS further documented that R7 received a scheduled pain medication regimen, as-needed (PRN) medication, and non-medication interventions for pain. R7 had almost constant pain and a fall the previous month. R7 received occupational and physical therapy services. R7's Care Plan dated 04/20/26, documented R7 was at risk for falls, had a potential alteration in the ability to perform activities of daily living (ADL) related to weakness and urinary incontinence, with the following documented approaches: On 11/21/25, ensure R7 was wearing proper, non-skid, well-maintained footwear. Keep the call light in reach at all times. Provide an environment free of clutter. On 01/03/26, R7 was sent to the emergency room related to falling and re-dislocating the hip. No changes to the care plan at that time. On 01/17/26, R7 had right hip precautions. The directed R7 not to cross legs, move leg backwards, and point toe out to the side. Do not turn from the operative leg with foot planted. Two staff assist with a full lift, do not ambulate. R7's knees give out at random times, then fall. On 01/21/26, have an abductor pillow/brace/ball in place at all times except when bathing. On 01/22/26, nursing will check and change at night during rounds per R7 request. R& was not to be taken to the bathroom at night. On 01/25/26, exit alarm at all times, and check to make sure each shift is functioning properly. On 01/29/26, no plastic chucks in the recliner or wheelchair. Use the commode in the room instead of the toilet to limit backward stepping. On 02/09/26, 30-minute safety checks, place a noodle (round Styrofoam tube) at the outer edge of the bed, and a full mattress next to the bed as an extension. On 04/17/26, staff will transfer with two-person assistance and a full lift. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	The Progress Note dated 01/03/26 at 02:09 AM documented staff taking R7 to the toilet. R7 was not standing or walking. Another staff member came to help and used the sit-to-stand lift when R7's foot came off the foot stand. Staff tried to get the foot back on the stand, but R7 started to sit down and was lowered to the floor. The nurse came to the room, and R7 was lying on the floor, and the right leg looked like the letter L backwards, as if the hip was popped out of the socket. R7 screamed when staff touched the leg and hip. R7 was sent to the emergency room. The Fall Investigation documented the incident as isolated, with no harm factors having contributed, with a summary as a witnessed fall, lowered to the floor by staff after R7's foot came off the foot stand of the lift. Active range of motion (AROM) to upper and lower extremities at baseline. The care plan was reviewed, and an adjustment for fall prevention was added to the care plan. The fall investigation lacked root cause analysis. The Progress Note, dated 01/17/26 at 11:07 AM, documented that staff walked R7 to her bed when her knees went out on her. Staff lowered R7 to the floor in front of the bed. R7 was not hurt, and the new intervention at the time was to pivot transfer to a wheelchair and then take her to where she needed to go. The Fall Investigation Note documented R7 had a witnessed fall, no harm, and transfer status of two staff with a sit-to-stand lift or two-person pivot transfer. AROM to the upper and lower extremities at baseline. The intervention of the care plan was reviewed, and adjustments for fall prevention were added to the care plan. The fall investigation lacked root cause analysis. The Progress Note dated 01/20/26 at 03:49 PM, documented that occupational therapy staff notified the nurse that R7 believed her hip was dislocated and R7 wanted to be evaluated by a doctor. The nurse was then told that the staff was assisting R7 to the toilet when R7 was lowered to the floor to prevent a fall. R7 was assisted by two staff from the floor to the toilet, then assisted by occupational therapy staff and two staff to the wheelchair. R7 left with the emergency medical service (EMS). The Fall Investigation documented that R7 had a witnessed fall, no harm, and the event was ongoing. No factors in the facility had contributed to concern. R7 transfer status of two staff with a sit-to-stand lift or a two-person pivot transfer. R7 was lowered to the floor when staff attempted to pivot transfer to the toilet, and R7 became weak. AROM to both lower and upper extremities with R7 at baseline. The intervention was a review of the care plan and adjustments for fall prevention added to the care plan. The fall investigation lacked root cause analysis. The Progress Note dated 01/29/26 at 07:22 AM, documented that R7 was attempting to recline in the recliner and hit the wrong button, causing the chair to go to a standing position, and R7 slid onto the floor. Upon assessment, R7 had an internal rotation of the right leg. R7 left the facility with EMS. The Fall Investigation documented an unwitnessed fall, no harm ongoing event, transfer status two staff with a sit-to-stand lift or two-person pivot transfer. The motion chair was elevated, and the resident slid down to the floor. AROM to both upper and lower extremities. The right lower extremity abduction brace was unfastened, and the right lower extremity was misaligned. EMS was notified, and R7 was transferred for a reduction of the right lower extremity. The intervention of the care plan was reviewed, and adjustments for fall prevention were added to the care plan. The fall investigation lacked root cause analysis. The Progress Note dated 02/08/26 at 09:43 PM documented R7 lying on her left side on the floor. R7 (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	reported rolling out of bed. No external rotation to lower extremities, and R7 was able to move all extremities without complaints of pain. A pool noodle was put under the edge of the sheet, and a fall mat was put on the floor next to the bed. The Fall Investigation documented an unwitnessed fall, no harm, and an ongoing event. R7 reported rolling over and falling out of bed. Head-to-toe assessment by nurse, AROM to both upper and lower extremities, abduction (movement of a limb away from the body) device in place, no apparent injuries. Three staff assisted from the floor and returned to bed. The intervention of the care plan was reviewed, and adjustments for fall prevention were added to the care plan. The fall investigation lacked root cause analysis. The Progress Note dated 05/01/26 at 02:50 AM, documented at 11:30 PM, R7 was noted on her knees next to the bed, holding onto the bed rail. R7's room was rearranged due to R7's history of rolling out of bed. No injuries were noted, and staff transferred her back into bed. Upon request, no Fall Investigation was provided for the fall on 05/01/26. On 05/05/26 at 02:37 PM, R7 sat in her room in a recliner with the foot of the chair elevated. She was covered with a blanket and had her eyes closed. She had a mattress on the floor beneath the elevated footrest, and the call light was attached to chair. On 05/07/26 at 07:30 AM, Certified Nurse Aide (CNA) M reported staff used the alarm, took R7 to activities, and used a full body lift for all transfers to prevent falls. CNA M said staff also ensured a brace to R7's right leg was in place at all times, ensured the fall mat was in place, and made sure the resident was in bed or recliner when in the room with the fall mat on the floor to prevent falls. On 05/07/26 at 08:00 AM, Licensed Nurse (LN) G reported the staff stopped using the sit-to-stand lift and used a full-body lift for transfers for R7. LN G said staff had also tried multiple braces to the right leg, and were careful when transferring R7, ensuring she was in bed or the recliner with a fall mat on the floor. On 05/07/26 at 11:30 AM, Administrative Nurse D reported that the facility did not utilize a root cause analysis related to falls, and the facility did not have a structured fall committee or investigations related to falls. Administrative Nurse D verified that some of R7's interventions were repeated and not effective for the prevention of falls. The facility's Assessing Falls and Their Causes policy, dated 03/2018, documented falls are a leading cause of morbidity and mortality among the elderly in nursing homes. Within 24 hours of a fall, begin to try to identify possible or likely causes of the incident. Refer to resident-specific evidence, including medical history, known functional impairments, etc. Continue to collect and evaluate information until the cause of falling is identified or it is determined that the cause cannot be found. - The Electronic Medical Record (EMR) for R14 documented diagnoses of Alzheimer's disease (a progressive mental deterioration characterized by confusion and memory failure), repeated falls, restlessness, and agitation (feeling of aggravation or restlessness brought on by a provocation or a medical condition). The Quarterly Minimum Data Set (MDS, dated [DATE]) documented R14 had long and short-term memory problems with severely impaired decision-making skills. R14 required staff assistance with (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	transfers and was independent with mobility and transfers. R14 had upper functional impairment on both sides, wandered daily, and did not have any falls. The Quarterly MDS, dated 02/26/26, documented R14 had long and short-term memory problems with severely impaired decision-making skills. R14 required substantial staff assistance with transfers and was independent with mobility and ambulation. R15 had upper functional impairment on both sides, wandered daily, and had one non-injury fall. The Fall Risk Assessments, dated 05/22/25, 07/15/25, 08/22/25, 10/20/25, 11/11/25, 02/22/26, and 02/27/26 documented R14 was at risk for falls. R14's 02/18/26 Care Plan included the following interventions for R14: 09/28/21- 30-minute safety checks, provide R14 with an environment free of clutter, always keep the call light within reach, and ensure she wears proper nonskid, well-maintained footwear. 06/23/24- Place a pool noodle in bed at nighttime and place bed in the lowest position. 11/20/24- 30-minute safety checks, ensure she wore shoes and slipper socks while resting in bed. 07/15/25- shut her closet doors. 08/12/25- no changes to the care plan. 10/20/25- Maintenance will fix the bed or change out the bed. 11/11/25- no changes to the care plan. The Fall Investigation, dated 07/15/25 at 08:35 PM, documented that R14 was on the floor in her closet with her legs outstretched. The fall was unwitnessed, and R14 could not give a description of what she was doing. R14 was assessed, and no injury was found. The Fall Investigation, dated 08/12/25 at 07:51 AM, documented R14 walked with staff in the TV room and started to sit down before she reached her recliner. Staff lowered R14 to the floor. The Fall Investigation, dated 10/20/25 at 05:15 AM, documented R14 sat on the edge of the bed as staff tried to change her soiled shirt. R14 started to get combative with the staff, and she slid off the bed. R14 did not sustain any injury and was assisted by staff. The Fall Investigation, dated 11/11/25 at 11:31 PM, documented R14 was found on the floor in her room. R14 could not give a description of what she was doing. R14 was assessed, and no injury was found. The Fall Investigation, dated 11/26/25 at 04:33 PM, documented R14 was on the floor in her room in front of the closet. R14 could not give a description of what she was doing. R14 was assessed, and two staff members assisted her off the floor and placed her in her recliner. The Fall Investigation, dated 02/27/26 at 01:38 PM, documented Staff lowered R14 to the floor to prevent her from slipping from a dining room chair to the floor. R14 was assessed and did not sustain (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	any injury. The Fall Investigation, dated 04/28/26 at 04:19 PM, documented R14 appeared to have fallen asleep in a recliner in the TV room and fell forward out of the recliner. R14 sustained an abrasion on her forehead. Staff assisted R14 off the floor. On 05/06/26 at 08:15 AM, R14 independently ambulated down the hall to go to the dining table for breakfast. On 05/06/26 at 07:45 AM, Certified Medication Aide (CMA) R stated R14 was independent with transfers and ambulation. CMA R stated R14 had fallen, did not know what fall interventions were in place for her, but staff walked with her as needed. On 05/07/26 at 10:00 AM, Licensed Nurse (LN) H stated she had a recent fall that they had charted on last week. LN H said she thought R14 had a bed alarm, but was not sure what fall interventions were in place for R14. On 05/07/26 at 11:14 AM, Administrative Nurse D stated there was no fall committee to go over interventions for falls. She stated she did the investigations but did not do root cause analysis when there was a fall. The facility's Assessing Falls and Their Causes policy, dated March 2018, documented if the resident had a fall, staff try to identify possible or likely causes of the incident o likely causes of the incident. The facility would continue to collect and evaluate information until the cause of the fall was identified or it was determined that the cause could not be found. After a fall, the resident's family, physician, and director of nursing would be notified. - The Electronic Medical Record (EMR) for R31 documented diagnoses of memory deficit, pain, and muscle weakness. The Quarterly Minimum Data Set (MDS), dated [DATE], documented R31 had a Brief Interview for Mental Status (BIMS) score of 7, which indicated severely impaired cognition. R31 was independent with transfers and mobility, and transfers. R31 had no upper or lower functional impairment, wandered daily, and had no falls. The Annual MDS dated 03/14/26, documented R31 had a Brief Interview for Mental Status (BIMS) score of 3, which indicated severely impaired cognition. R31 was independent with transfers and mobility, and transfers. R31 had no upper or lower functional impairment, wandered daily, and had one fall with injury. The Fall Risk Assessment, dated 09/13/25, 11/19/25, 12/14/25, and 03/12/26, documented R31 was at risk for falls. The 03/19/26 Care Plan included the following interventions for R31: 03/07/25- Always keep call light in reach, ensure she wears proper, non-skid, well-maintained footwear. 04/16/25- Provide her with an environment free of clutter. (continued on next page)

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F 0689 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	04/20/25- 30-minute safety checks 11/19/25- No changes to the care plan at this time. 03/16/26- Remove all regular socks from the room and replace them with slipper socks. The Fall Investigation, dated 11/19/25 at 5:03 PM, documented R31 had an unwitnessed fall after she attempted to sit in her wheelchair that was full of books. R31 stated she tried to sit for a minute and slid out of the wheelchair. R31 did not sustain any injury, and her wheelchair was removed from her room. The Fall Investigation, dated 03/12/26 at 04:32 AM, documented that staff heard someone screaming for help. R31 was on the floor in front of her chair and stated she tried to grab her shoes and slid off the bed. R31 had a large lump on the right side of her forehead and complained of pain in her neck and back. R31 was sent to the hospital for an evaluation. R31 returned to the facility without new orders. On 05/05/26 at 12:10 PM, staff walked beside R31down the hall to the dining room table. On 05/06/26 at 07:45 AM, Certified Medication Aide (CMA) R stated R31 has had recent falls, and they told her to try to call for assistance when she ambulated. When asked if she was oriented enough to remember to call, CMA R stated that it depended upon the day On 05/07/26 at 10:00 AM, Licensed Nurse (LN) H stated R31 had not had any recent falls that she was aware of and was not sure what fall investigations were in place for R31. On 05/07/26 at 11:14 AM, Administrative Nurse D stated there was no fall committee to go over interventions for falls. She stated she does the investigations, but does not do root cause analysis when there is a fall. The facility's Assessing Falls and Their Causes policy, dated March 2018, documented if the resident had a fall, staff try to identify possible or likely causes of the incident o likely causes of the incident. The facility would continue to collect and evaluate information until the cause of the fall was identified or it was determined that the cause could not be found. After a fall, the resident's family, physician, and director of nursing would be notified.

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide enough food/fluids to maintain a resident's health. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R) 6 received the necessary care and services to prevent an ongoing insidious weight loss when staff failed to notify the physician of the weight loss and failed to ensure the physician received the dietician's recommendations for an appetite stimulant. Findings included:- R6's Electronic Medical Record (EMR) included diagnoses of dehydration, low back pain, repeated falls, depression (a mood disorder that causes a persistent feeling of sadness and loss of interest), hypokalemia (low level of potassium in the blood), and heartburn. R6's admission Minimum Data Set (MDS), dated [DATE], documented that R6 had severe cognitive impairment, hallucinations (sensing things while awake that appear to be real, but the mind created), and delusions (untrue, persistent belief or perception held by a person although evidence shows it was untrue). R6 utilized a walker and wheelchair for mobility and required supervision/touching assistance with eating, personal hygiene, upper-body dressing, bed mobility, and lying-to-sitting on the edge of the bed. R6 required partial/moderate assistance with sit-to-standing, bed-to-chair transfers, and walking ten to 50 feet. R6 was 60 inches tall, weighed 87 pounds (lbs.), and had one stage two pressure ulcer (partial-thickness skin loss into but no deeper than the dermis, including intact or ruptured blisters). The MDS further documented that R6 received an antidepressant (a class of medications used to treat mood disorders). The Nutrition Care Area Assessment (CAA), dated 03/10/26, lacked an analysis or summary. R6's Nutritional Status Care Plan dated 03/12/26, directed staff to encourage R6 with adequate fluid intake at meals and ensure fresh water in the room, encourage eating meals in the dining room, and off-menu selections daily. The plan noted R6 was on a regular texture diet as tolerated, and directed staff to weigh weekly. The Physician Order dated 03/03/26, documented R6 had a regular soft-texture diet as tolerated with regular fluids with meals. The Registered Dietitian (RD) Progress Notes dated 03/04/06, documented R6 had been admitted on [DATE], had a height of 60 inches, and weighed 87.6 lbs. R6's food preferences included orange juice, coffee, and Coke. R6 had very few food dislikes and reported liking food. The RD suggested adding a 120 cubic centimeter (cc) protein supplement drink twice a day. The protein supplement had been implemented. The RD Nutritional Progress Note dated 03/18/26, documented a follow-up to the initial nutritional assessment, that R6's weight on 03/11/26 was 80 lbs., down 8.7%. The RD suggested increasing the protein supplement drink to three times a day and adding 120 cc of Gelatin (a high protein, ready-to-eat gelatin supplement) at lunch. These RD's suggestions had been implemented. R6's EMR lacked evidence staff notified the physician of the weight loss. The RD Nutritional Progress Note dated 04/01/26, documented a follow-up to the 03/18/26 regarding weight status. The note documented that R6 had been refusing the Gelatin. R6's current weight was 73.2 lbs., a weight loss of 14.6 lbs. The RD suggested increasing the protein supplement drink to four times a day.R6's EMR lacked evidence staff notified the physician of the continued weight loss.The RD Nutritional Progress Note dated 04/15/26, documented R6's current weight was 73.2 lbs. R6 ate 1-25% of meals and ate more than that at times, but also ate nothing at other meals. The RD documented consideration of whether the physician desired to try medication to increase appetite, noting poor intake and weight loss. The EMR, dated 04/29/26, recorded R6's weight of 69.4 lbs., a 20.6% weight loss since admission on [DATE].R6's EMR lacked physician notification of the continued significant weight loss, a reevaluation, or new recommendation from the RD. On 05/06/26 at 10:20 AM, R6 remained in bed with her eyes closed and in night clothing. On 05/06/26 at 10:45 AM, Licensed Nurse (LN) I reported R6 had refused earlier attempts to eat breakfast or get out of bed. LN stated the resident was awake at night quite a bit. LN I did not know if R6 was offered anything to eat or if care plan interventions addressed weight loss. LN reported R6 would drink the supplement while taking her medication in the morning. On 05/06/26 at 11:37 AM, Dietary Staff CC reported she usually tried to review the weights and attempted to be part of the care plan team, but recently had not been able to (continued on next page)

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F 0692 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	due to staffing issues in the kitchen. Dietary Staff CC reported the facility did not have an always-available menu, and the alternative menu consisted of what may have been left over from the previous day's menu, but staff could offer sandwiches to residents if the residents did not like what was on the menu. Dietary Staff CC could not verify if staff offered R6 alternatives or snacks. On 05/06/26 at 11:39 AM, Consultant Staff GG reported coming to the facility every other week, reviewing weights, and making recommendations as needed. Consultant Staff GG verified R6 had significant weight loss and verified she had made recommendations. Consultant Staff GG reported it was the responsibility of the nursing staff to notify the physicians of significant weight loss and recommendations so could not say if R6's physician had been notified of the continued significant weight loss. On 05/06/26 at 01:17 PM, Certified Nurse Aide (CNA) N reported R6 enjoyed going to a local restaurant with a friend and would eat well there. CNA stated R6 would eat poppers and hamburgers. On 05/06/26 at 03:49 PM, Administrative Nurse D verified R6's physician had not been notified of continued significant weight loss. Administrative Nurse D confirmed R6's care plan lacked resident-centered interventions including R6's preferences. Upon request, the facility did not provide a weight loss policy.

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Provide safe, appropriate dialysis care/services for a resident who requires such services. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** Based on observation, interview, and record review, the facility failed to ensure Resident (R) 41 received care and services for dialysis (a procedure where impurities or wastes are removed from the blood) consistent with professional standards of practice, which included a contract for service, nursing assessments, or ongoing communication and collaboration with the dialysis facility. Findings included:- R41's Electronic Medical Record (EMR) documented diagnoses of chronic hypertensive(elevated blood pressure) heart disease, end-stage renal disease (ESRD-a terminal disease of the kidneys), depressive disorder, stage three pressure ulcer (full-thickness pressure injury extending through the skin into the tissue below) to the sacral (large triangular bone/area between the two hip bones) region, and shock. R41's admission Minimum Data Set (MDS), dated [DATE], documented that R41 had intact cognition. R41 had functional range of motion impairment of the upper extremity on one side and required substantial/maximal assistance with toilet hygiene, lower body dressing, and personal hygiene. R41 required supervision/touch assistance with bed rolling, sit to lying on the side of the bed, chair/bed to chair transferring, and walking ten to 50 feet. R41 was continent of urine and bowel, had occasional pain and shortness of breath. The MDS further documented that R41 had difficulty or pain with swallowing. R41 had nutritional approaches and had a pressure ulcer. She received an anticoagulant, opioid, and antidepressant medications. The MDS lacked coding for dialysis in special treatment or procedures. The Care Area Analysis (CAA), dated 04/28/26, lacked an analysis or summary of findings for all triggered areas. R41's Care Plan dated 04/30/26, documented that she had end-stage renal failure and dialysis. The care plan directed staff R41 had a 1.5-liter fluid restriction in 24 hours. It instructed staff to keep the port clean, dry, and covered and to follow recommendations and instructions from dialysis. Staff was to obtain a weight on Monday, Wednesday, and Friday before leaving for dialysis, and to send evening medications. The care plan lacked interventions related to access site assessment, the location of the dialysis center, the appointment (chair) time, and the specific instructions for allocation of fluids between the dietary and nursing departments. The Physician Order dated 04/23/26, directed staff to weigh R41 before the dialysis appointment, put the weight on the paperwork, and to get the evening medications ready, then place them in a to-go envelope on Mondays, Wednesdays, and Fridays for diagnosis of end-stage renal disease. The Physician Order dated 04/29/26, directed staff to record intake at the end of each shift related to a fluid restriction of 1.5 liters every 24 hours. The Physician Order, dated 05/04/26, directed staff to increase the fluid restriction to two liters in 24 hours. R41's Physician Orders lacked a specific dialysis facility that R41 was attending. The Progress Note dated 04/21/26 at 02:24 PM, documented R41 admitted to skilled care for physical and occupational therapy following hospitalization for end-stage renal failure, cardiac failure, and shock. R41 will do hemodialysis (a procedure where impurities or wastes are removed from the blood) three days a week in Nebraska, where her significant other or family would take her. R41 was on a renal diet with a 1.5-liter fluid restriction, received wound care, and interventions were in place, including strict monitoring for infections since R41 had dialysis. The EMR had documented R41's weights before the dialysis appointment, but lacked documentation of an assessment of the dialysis port for signs and symptoms of infection and bleeding. The EMR fluid intake tracking revealed R41 had not reached the designated intake of fluid intake and/or restriction. On 05/06/26 at 08:59 AM, staff delivered a breakfast tray to R41's room, and reported R41 would be leaving for dialysis at 09:30 AM. R41 had a visitor in the room. On 05/06/26 at 11:59 AM, Dietary Staff (DS) CC reported R41 received room trays at mealtimes. DS CC reported the dietary department provided 400 milliliters (ml) for each meal, and the nursing department provided the remaining fluids of the fluid restriction. DS CC stated the nursing department was responsible for the documentation of the intake of residents who had room trays. On 05/06/26 at 09:03 AM, Licensed Nurse (LN) H reported R41's dialysis appointment was at 02:30 PM. LN H stated (continued on next page)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	175506	A. Building B. Wing	05/07/2026

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Andbe Home, Inc	201 W Crane Street Norton, KS 67654

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F 0698 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	the facility sent a transfer form with R41's weights, vital signs, and any other changes to orders or condition. R41's family or significant other took R41 to the dialysis center but did not know the specifics of the dialysis center's address or phone number. LN H stated no communication was returned with the resident following the dialysis treatment or regarding the condition or tolerance of treatment. LN H was uncertain who was responsible for monitoring the fluid restriction total intake for 24 hours, and the nursing staff. On 05/06/26 at 03:16 PM, Administrative Nurse D verified R41's physician orders and care plan lacked dialysis-specific instruction for the related assessment of shunt (tube or device implanted in the body to redirect a body fluid from one cavity to another) care, signs and symptoms of infection, fluid delegation between the dietary and nursing staff, and conditions reported nursing staff should be tracking the fluid intake. On 05/06/26 at 03:50 PM, Administrative Staff A verified the facility lacked contractual services with the dialysis center, and lacked information related to where R41 had been receiving dialysis treatment following admission of R41to the facility. Upon request, the facility did not provide a dialysis policy.

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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 adhere to infection control procedures related to Enhanced Barrier Precautions (EBP -an infection control intervention designated to reduce transmission of resistant organisms that employs targeted gown and glove used during high contact resident care activities), when emptying the indwelling catheter for Resident (R)8. Findings included: - On 05/07/26 at 12:55 PM, observation revealed R8 sat in a wheelchair in his room. Certified Medication Aide (CMA) R entered the room and donned gloves only, no gown. CMA R cleansed the end of the R8's catheter tubing, drained the amber urine from the catheter collection bag into the urine collection container, then wiped off the catheter spout with alcohol. She replaced the end of the catheter spout and closed the clamp. CMA R then removed her gloves and washed her hands. Further observation revealed R8's room lacked a sign posted on the inside of the resident's room that provided instructions on EBP and the use of personal protective equipment (PPE - gown and gloves) when staff provided R8 catheter care. R8's room lacked the necessary PPE equipment, including gowns. On 05/07/26 at 10:30 AM, Administrative Nurse D verified that the staff should wear PPE when providing R8 with catheter care. Administrative Nurse D said the facility would post signage and provide the resident's rooms with PPE. Administrative Nurse D said she would provide education to the staff regarding EBP and when the staff should wear PPE for resident care. The facility's Infection Prevention and Control Program policy dated 2026, documented the facility would provide a safe, sanitary, and comfortable environment and help prevent the development and transmission of communicable diseases and infections. The Infection Prevention and Control program establishes a facility-wide system to prevent, identify, investigate, report, and control communicable diseases and infections among residents, staff, and visitors. The Infection Prevention Nurse would conduct ongoing surveillance for Healthcare-Associated Infections (HAIs) and other epidemiologically significant infections that have a substantial impact on potential residents' outcomes, and that may require transmission-based precautions and other preventative measures.

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F 0838 Level of Harm - Potential for minimal harm Residents Affected - Many	Conduct and document a facility-wide assessment to determine what resources are necessary to care for residents competently during both day-to-day operations (including nights and weekends) and emergencies. Based on interviews and record review, the facility failed to conduct a thorough facility-wide assessment to determine the resources necessary to care for residents competently during both day-to-day operations and emergencies. Findings included: - On 05/05/26 at 10:00 AM, Administrative Staff A provided an undated Long-Term Care Self-Assessment. Review of the assessment revealed the assessment failed to identify the specific staffing levels needed for each unit and identify the number of Registered Nurses (RN), Licensed Nurses (LPN/LVN), Certified Medication Aides (CMA), and Certified Nurse's Aide (CNA) needed for each unit, patient acuity, and census. The assessment also lacked staffing levels required for each shift to include evenings and weekends. The assessment did not document the staff competencies and skill sets necessary to provide the level and types of care needed for the specific resident populations and did not fully document any contractual agreements to outside providers for services available to residents in the facility for laboratory, radiology, therapy, hospital or transportation. On 05/07/26 at 09:10 AM, Administrative Staff A stated she had reviewed the assessment. Administrative Staff A stated staffing breakdown per unit should be completed and confirmed the assessment did not contain that information. Administrative Staff A confirmed the facility assessment lacked completion. She said she needed to work on the assessment and stated she would try to find some outside sources to help her with the review and update.Upon request, the facility lacked a Facility Assessment Policy.